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JANUARY 1988

# JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

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Georgia  
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Legal Issues re AIDS  
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Bethesda, MD 20892

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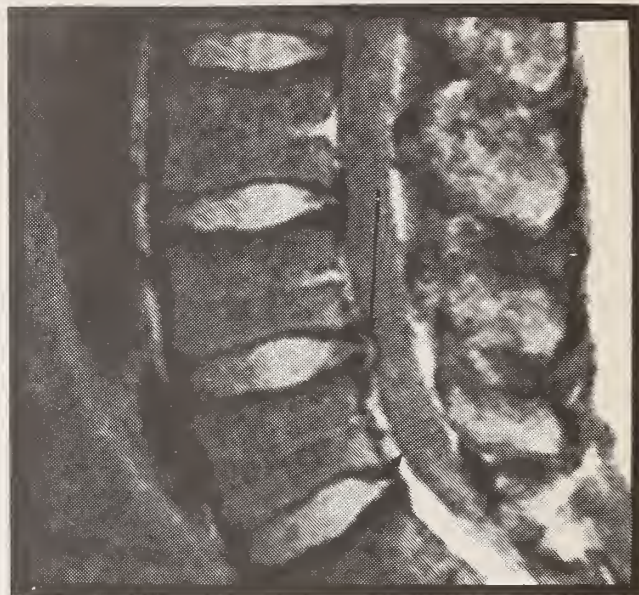
# MR UPDATE

## MRI is Rapidly Replacing CT & Myelography For Evaluation of HNP

### LUMBAR SPINE

**HISTORY:** This 38-year-old male complained of recent onset of low back pain radiating to left lower extremity.

**SCAN:** This midline sagittal image demonstrates the high intensity (white) discs lying between the vertebral bodies. The L4-5 disc is herniated posteriorly with a "mushroom configuration" (long arrow). CSF in the spinal canal is gray (short arrow), and this CSF column is indented by the herniated disc material at the L4-5 level (long arrow). Axial images at the other levels demonstrated that the high intensity disc material is contained, and disc herniation can be confidently excluded at all the other levels.



**MRI HIGHLIGHTS:** Lumbar and cervical coil MRI is rapidly replacing myelography and computerized tomography for initial evaluation of suspected disc herniation and suspected spinal stenosis. Standard MR examination shows the entire lumbar or cervical spine, the spinal canal and the paraspinal region. Causes of low back or neck pain and sciatica are well demonstrated without injection of contrast material and without ionizing radiation. The bony structures are well shown, and destructive bony lesions and extraosseous extension of bony lesions are routinely demonstrated on MRI. Intraspinal neoplasms are also confidently detectable.



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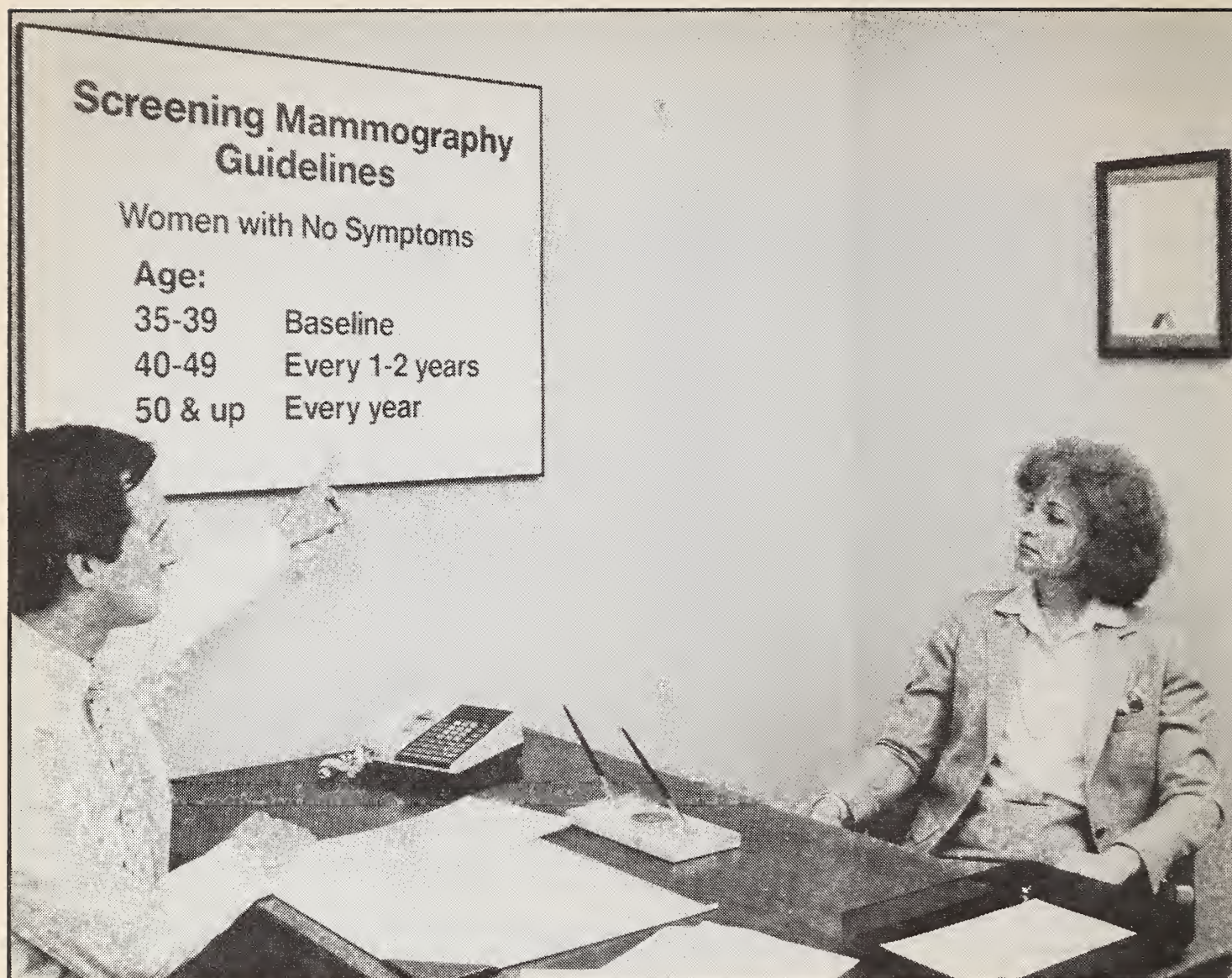
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COVER

This issue features many topics of interest to physicians that are before the 1988 Georgia Legislature.

Photograph by Chuck Rogers, of Rogers and Bigit, Atlanta.





# What will you tell her about screening mammography?

Many of your patients will hear about screening mammography through a program launched by the American Cancer Society and the American College of Radiology, and they may come to you with questions. What will you tell them?

We hope you'll encourage them to have a screening mammogram, because that, along with

your regular breast examinations and their monthly self examinations, offers the best chance of early detection of breast cancer, a disease which will strike one woman in 10.

If you have questions about breast cancer detection for asymptomatic women, please contact us.



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- C. Southwest Georgia's only inpatient rehabilitation facility

## II. Diagnoses treated

- A. Stroke and neurological diseases
- B. Spinal cord injury
- C. Head injury
- D. Arthritis
- E. Pediatric neuromuscular diseases
- F. Amputee
- G. Burns

## III. Services available

- A. Rehabilitative nursing
- B. Rehabilitative therapy
  - 1. Physical therapy
  - 2. Occupational therapy
  - 3. Speech and language pathology
  - 4. Therapeutic recreation
- C. Psychology
- D. Social work
- E. Vocational counseling
- F. Prosthetics and orthotics

## IV. Special procedures

- A. Nerve conduction studies
- B. Electromyography
- C. Evoked potentials

## V. Medical Director

- A. Board certified physiatrist
- B. Oversees medical and physical rehabilitation of all patients
- C. On campus office

## VI. Multidisciplinary team approach

- A. Individualized treatment plans
- B. Weekly team conferences
- C. Outside consults as needed



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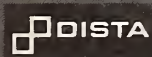
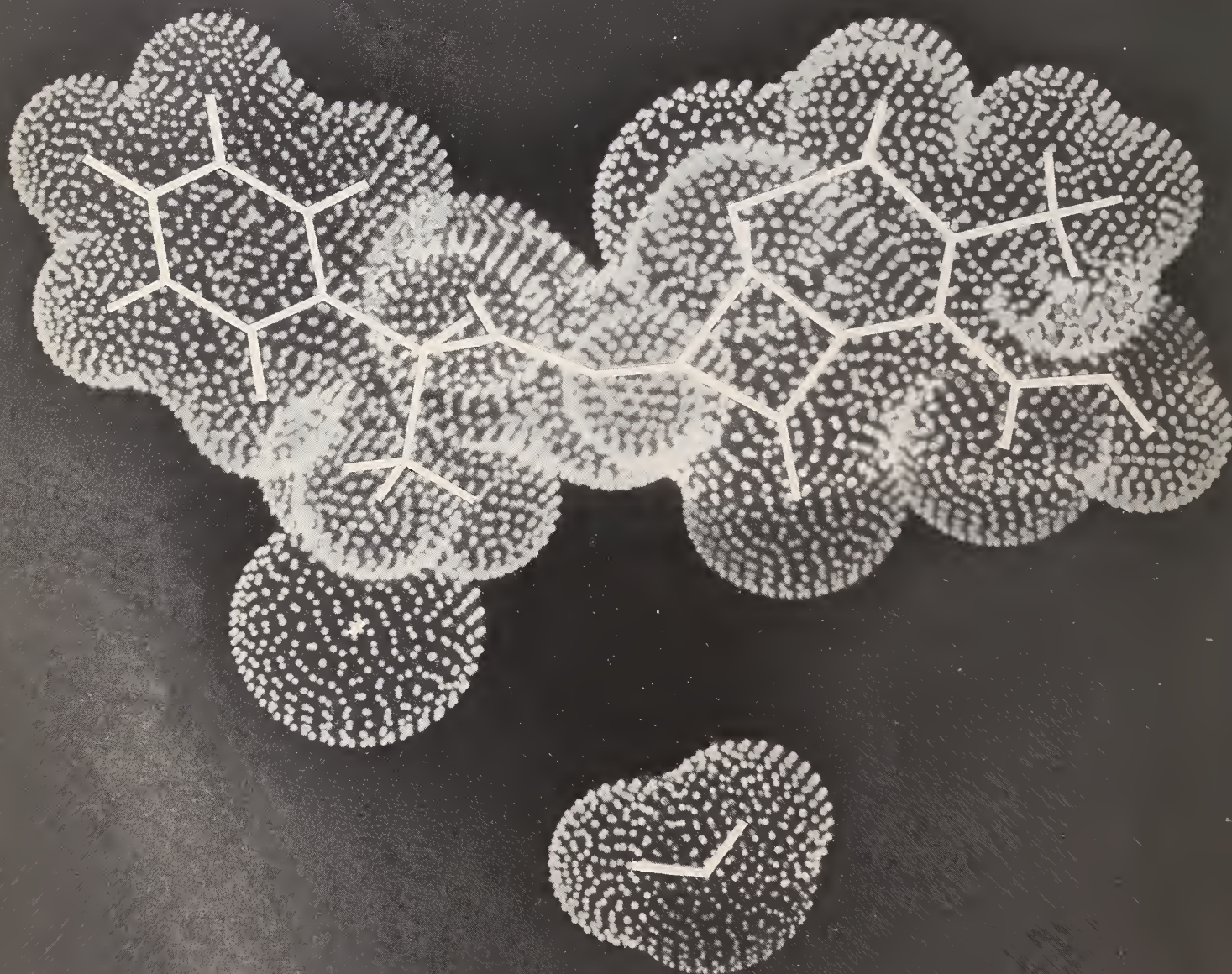


ANNOUNCING

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**cephalexin hydrochloride monohydrate**



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# Convenient 500-mg b.i.d. dosage and demonstrated effectiveness for treatment of:

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- pharyngitis‡

- New hydrochloride salt form of cephalexin—requires no conversion in the stomach before absorption
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- May be taken without regard to meals



For other indicated infections, 250-mg tablets available  
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Priced less than Keflex® (cephalexin)

Keftab is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-sensitive patients.

Penicillin is the drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever.

Due to susceptible strains of *Staphylococcus aureus* and/or  $\beta$ -hemolytic streptococci  
Due to susceptible strains of *Escherichia coli*, *Proteus mirabilis*, and *Klebsiella* sp  
Due to susceptible strains of group A  $\beta$ -hemolytic streptococci.

## KEFTAB™

(cephalexin hydrochloride monohydrate)

**Summary:** Consult the package literature for prescribing information.

### Indications and Usage:

*Respiratory tract infections* caused by susceptible strains of *Streptococcus pneumoniae* and group A  $\beta$ -hemolytic streptococci.

*Skin and skin structure infections* caused by susceptible strains of *Staphylococcus aureus* and/or  $\beta$ -hemolytic streptococci.

*Bone infections* caused by susceptible strains of *S aureus* and/or *Proteus mirabilis*.

*Genitourinary tract infections*, including acute prostatitis, caused by susceptible strains of *Escherichia coli*, *P mirabilis*, and *Klebsiella* sp.

**Contraindication:** Known allergy to cephalosporins.

**Warnings:** KEFTAB SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

### Precautions:

- Discontinue Keftab in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Keftab should be administered cautiously in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy and lactation. Cephalexin is excreted in mother's milk. Exercise caution in prescribing Keftab for these patients.
- Safety and effectiveness in children have not been established.

### Adverse Reactions:

- *Gastrointestinal*, including diarrhea and, rarely, nausea and vomiting. Transient hepatitis and cholestatic jaundice have been reported rarely.
- *Hypersensitivity* in the form of rash, urticaria, angioedema, and, rarely, erythema multiforme, Stevens-Johnson syndrome, or toxic epidermal necrolysis.
- *Anaphylaxis* has been reported.
- *Other reactions* have included genital/anal pruritus, genital moniliasis, vaginitis/vaginal discharge, dizziness, fatigue, headache, eosinophilia, neutropenia, and thrombocytopenia; reversible interstitial nephritis has been reported rarely.
- Cephalosporins have been implicated in triggering seizures, particularly in patients with renal impairment.
- *Abnormalities in laboratory test results* included slight elevations in aspartate aminotransferase (AST, SGOT) and alanine aminotransferase (ALT, SGPT). False-positive reactions for glucose in the urine may occur with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).



## PHYSICIANS, SCHEDULE SOME TIME FOR YOUR COUNTRY.

Many physicians would like to devote some time to their country in a local Army Reserve unit. We know that making a weekend commitment can be difficult for most physicians. So it is practical for the Army Reserve units to be flexible about time. It's worth discussing.

Incidentally, in addition to satisfying your own desire to serve your country, there are exceptional opportunities to do something totally different from a day-to-day routine. Opportunities to study new areas of medicine, meet new people in your specialty, and be a part of one of the world's most advanced medical teams.

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## FOR SURGEONS LOOKING FOR A CHALLENGE.

Your challenge could be the Army Reserve unit near you. It's a unit that requires the services of surgeons.

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You'll also have an opportunity to participate in a number of programs in which you'll be able to exchange views and information with other surgeons from all over the country.

The Army Reserve understands the time demands on a busy physician, so you can count on us to be totally flexible in making time for you to share your specialty with your country. We'll arrange your training program to work with your practice.

To find out about the benefits of serving with a nearby Army Reserve unit, we recommend you call our Army Medical Personnel Counselor.

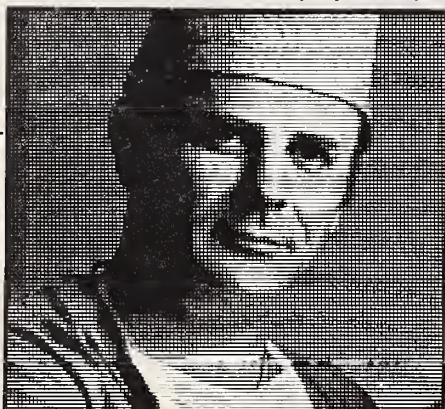
## PHYSICIANS, THERE ARE TWO KINDS OF FLEXIBILITY IN THE ARMY RESERVE WE THINK YOU'LL LIKE.

One, time. We know how tough it is for a busy physician to make weekend time commitments. So we offer flexible training programs that allow a physician to share some time with his or her country. We arrange a schedule to suit your requirements.

Two, the opportunity to explore other phases of medicine, to add a different kind of knowledge—the challenge of military health care. It's a flexibility which could prove to be both stimulating and rewarding, with the opportunity to participate in a variety of programs that can put you in contact with medical leaders from all over the country.

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# CALENDAR

## JANUARY

25-29 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

## FEBRUARY

1-5 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

4-9 — *Atlanta: American Academy of Orthopaedic Surgeons.* Category 1 credit. Contact AAOS, 222 S. Prospect, Park Ridge, IL 60068. PH:312/823-7168.

5-6 — *Atlanta: Georgia Psychiatric Physicians Association.* Category 1 credit. Contact James M. Moffett, 938 Peachtree St., Atlanta 30309. PH:404/876-7535 or 800/282-0224 (in Ga.)

5-6 — *Augusta: Advanced Trauma Life Support.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/721-3967.

12 — *Augusta: AIDS in Obstetrics and Gynecology and Family Practice.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/721-3967.

15-19 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

17 — *Atlanta: Pulmonary Forum.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

19 — *Macon: Mood Disorders and Treatment Failures: Therapist-Physician Collaboration.* Category 1 credit. Contact Office of CME, Med. Ctr. of Central Ga., 777 Hemlock St., Macon 31208. PH:912/744-1634.

20 — *Atlanta: Advances in the Treatment of Coronary Artery Disease.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

26-27 — *Augusta: Flexible Fiberoptic Sigmoidoscopy.* AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/721-3967.

27 — *Atlanta: Advances in the Treatment of Acute Ischemic Heart Disease.* Category 1 credit. Contact Office of CME, Emory Univ. School of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

27-28 — *Atlanta: Georgia Society of Anesthesiologists.* Category 1 credit. Contact Stanley Mogelnicki, M.D., 5665 Peachtree Dunwoody Rd., Atlanta 30342. PH:404/256-7324.

## MARCH

5 — *Atlanta: Cancer Care in Community Hospitals III: Breast Cancer.* Category 1 credit. Contact Janet Bonfiglio, Am. Cancer Soc., Ga. Div., 46 5th St., Atlanta 30308. PH:404/892-0026.

7-11 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

7-12 — *Augusta: Primary Care and Family Practice Symposium.* AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

10-17 — *Copper Mountain, CO: Snow Job in Gynecology and Obstetrics.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

11-12 — *Atlanta: 25th Annual Ophthalmology Conference.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

11-12 — *Sea Island: Critical Care Conference.* Category 1 credit. Contact Office of CME, Med. Ctr. of Central Ga., 777 Hemlock St., Macon 31208. PH:912-744-1634.

16-18 — *Hilton Head Island, SC: Clinical Management of Diabetes and Endocrine Disorders.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/721-3967.

18 — *Columbus: Day of Cancer — Breast and Occult Cancers.* Category 1 credit. Contact Janet Bonfiglio, Am. Cancer Soc., Ga. Div., 46 5th St. Atlanta 30308. PH:404/892-0026.

21-26 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

24-26 — *White Sulphur Springs, WV: 10th Annual Pediatric Postgraduate Course.* Sponsored by Scottish Rite Children's Hospital. Category 1 credit. Contact Darlene Baugus, SRCH, 1001 Johnson Ferry Rd., Atlanta 30363 PH:404/256-5252.



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<sup>†</sup>See Warnings and Precautions

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**T**HE AMERICAN HOSPITAL Association, in its recently released **AIDS policies**, recommends universal precautions in treating AIDS patients. The Centers for Disease Control in Atlanta has long advocated the procedure, which means that health care workers treat all patients as if they were infected with a blood-borne disease, and the Occupational Safety and Health Administration mandates it. All hospitals are now required to have policies and procedures for practicing universal precautions.

\* \* \*

**T**HE HEALTH CARE Financing Administration is scheduled to release its **mortality data on Medicare patients** December 14. The data will be published in several volumes, listing hospitals alphabetically by state. Immediately following each hospital's figures will be the hospital's comments and explanation of the numbers.

Georgia Hospital Association cautions that the death rates have noticeable shortcomings, to wit:

- The data include every death that occurs within 30 days of admission, regardless of its cause or location. Thus, a patient admitted for treatment of heart disease may be discharged and die of accidental causes a week later, yet the death is included in the data.

- The data do not take into account severity of illness.

- The data do not predict a hospital's future performance;

next year's rates can go up or down depending on the severity of illness of the patients, but the quality of care will remain the same.

At best, says GHA, the data indicate areas that do not fall within HCFA's norm; they do not identify quality problems.

\* \* \*

**M**EDICARE COSTS for patients are going up. Beginning January 1, patients will pay a \$540 deductible for hospital care — up \$20 from this year's \$520.

\* \* \*

**T**HE GOVERNMENT now requires that hospitals have written protocols for identifying potential **organ donors**. The protocols must do the following:

- Ensure that families of potential donors are aware that organ donation is possible,

- Ensure respect for each family's circumstances and beliefs, and

- Require that the hospital notify a designated organ procurement organization of potential donors.

The rules apply to any hospital receiving Medicare or Medicaid funds.

\* \* \*

**T**HE DEPARTMENT OF HEALTH and Human Services proposes to charge hospitals and other health care entities for use of a national **data bank containing information on disciplinary actions against physicians**.

HHS wants to require hospitals

to make requests every 2 years for data on disciplinary and malpractice actions taken against their physicians, and hospitals would be fined as much as \$10,000 for failure to do so.

The Health Care Practitioner Adverse Credentialing Data Bank was created last year by Congress to restrict incompetent practitioners from moving state to state without disclosing their past performances.

\* \* \*

**G**EOORGIA HOSPITAL Association has launched a broad campaign to help solve the **nursing shortage** in the state's hospitals. Among the efforts now in progress are:

- *A nursing recognition program.* Hospitals, patients, or community members are nominating nurses for recognition of their services to the health care professionals or to Georgia. The winner will be the nurse who has made the most outstanding contribution to hospital or community. GHA will honor the winner during National Hospital Week in May. It will use all the entries in media campaigns to promote nursing's image.

- *An essay contest* for high school seniors, with prizes of nursing school scholarships. GHA will have three state winners and six district winners.

- *Nursing recruitment* in Georgia's high schools. Hospital Nursing Administrators have received a recruitment packet from GHA to help them recruit students during career programs. ■



*Our Legislative Efforts  
Still Need You!*



*Jack F. Menendez, M.D.*

**T**HE LEGISLATIVE SESSION of the General Assembly is upon us. We need to continue to monitor events and give our input. In short, we need to do those things that we must in order to assure continued high quality health care for the people of Georgia. Each Session, there are 100-200 bills that impact on the health care of our citizens and are thus the legitimate concern of the physicians of this state. This year is no different. There is legislation concerning AIDS, mandatory CME, scope of optometric practice, informed consent, and many others.

**W**e have an expert lobbying team that can, with all its expertise, do so much. We the physicians must do the rest. We must familiarize ourselves with the issues that involve our profession, our very practices. We have to continue to volunteer a day or more as part of the Physician Involvement Program (PIP). We also need to continue to volunteer for the Doctor of the Day Program. By participating in these programs, we show legislators that we are involved and that we understand the issues surrounding health care. It's our best hope and only logical option. ■

*Jack F. Menendez*



## Journal NEWS

The May, 1987, issue of the *Journal*, which was a Special Issue devoted to breast cancer, won an American Cancer Society National Honor Citation Award at the Society's National Annual Meeting in New York City. Co-sponsored by the Georgia Division of the American Cancer Society and the MAG, this Special Issue of the *Journal* provided information on breast cancer screening, treatment, and patient rehabilitation to physicians throughout Georgia.

The American Cancer Society's Breast Cancer Detection Awareness program targeted the need to reach primary care physicians with information about early breast cancer detection. The centerpiece of the Georgia Division Breast Cancer Detection project was the *Journal*.

## QUOTES

*Genius, in one respect, is like gold — numbers of persons are constantly writing about both, who have neither.*

CHARLES CALEB COLTON

*Dry happniess is like dry bread. We eat, but we do not dine. I wish for the superfluous, the useless, the extravagant, for the too much, for that which is not good for anything.*

VICTOR HUGO

*It saves a lot of trouble, instead of having to earn money and save it, you just go and borrow it.*

WINSTON CHURCHILL

*Man is not the creature of circumstances, circumstances are the creatures of man.*

BENJAMIN DISRAELI

## NEW MEMBERS

Asihene, Regina J. — MAA — (Student), 2562 Farley St., East Point 30344

Bakin, Grant R., Internal Med./Emergency Med. — Clayton-Fayette — (Active N2), 1022 Cedar Forest Dr., Stone Mountain 30083

Balyeat, Ray M., Ophthalmology — MAA — (Resident), 1116 Pine Heights Dr., NE, Atlanta 30367-5201

Beville, Roger W., Family Practice — DeKalb — (Active), 755 Commerce Dr., Ste. 333, Decatur 30033

Binet, Eugene F., Radiology — Richmond — (Active), Dept. of Radiology, Medical College of Georgia, Augusta 30912

Black, J. Durward, Jr., Urology — Bartow — (Active N1), 962 Joe Frank Harris Parkway, Ste. 206, Cartersville 30120

Blackwelder, Reid B., Family Practice — Richmond — (Active), Dept. of Family Med., Medical College of Georgia, Augusta 30912

Brant, Jeffrey R., Ophthalmology — Bartow — (Active), 962 Joe Frank Harris Parkway, Ste. 201, Cartersville 30120

Britton, Linda J. — MAA — (Student), 475 Clifton Rd., Atlanta 30307

Brooks, William S., Diagnostic Radiology — Richmond — (Active), 2100 Central Ave., Augusta 30903

Brown, Cullen M., III, Family Practice — Bartow — (Active N2), 962 Joe Frank Harris Parkway, Ste. 203, Cartersville 30120

Brunson, W. Edgar — MAA — (Student), 23 Vernon Glen Ct., Atlanta 30338

Carrington, Elaine — MAA — (Student), 2733 Rainbow Forest Dr., Decatur 30034

Cassity, Oscar T., Jr., Emergency Med. — Walker-Catoosa-Dade — (Active), 100 Gross Crescent Cir., Fort Oglethorpe 30742

Clary, Diane D., Diagnostic Radiology — MAA — (Active N2), 6500 Vernon Woods Dr., #C-23, Atlanta 30328

Cole, Frank N., Internal Med. — Clayton-Fayette — (Active), 101 Yorktown Dr., Fayetteville 30214

Coursey-Prah, Debora L., Diagnostic Radiology — Clayton-Fayette — (Active N2), 102 White Oak Trail, Peachtree City 30269

Crozier, Mark A., Gynecology/Oncology — MAA — (Active N2), 5669 Peachtree Dunwoody Rd., Ste. 100, Atlanta 30342

Davis, Lee S., Anesthesiology — MAA — (Active N2), 60 Montgomery Ferry Dr., NE, Atlanta 30309

Detlefs, Richard L., Dermatology — MAA — (Active N2), 478 Peachtree St., Ste. 915-A Doctors Building, Atlanta 30308

Dickens, Andrew F. — MAA — (Student), 1423 Tuxworth Cir., Decatur 30033

Dobson, Franklin M., Pediatrics/Neonatology — Dougherty — (Active), Phoebe Putney Memorial Hospital, P.O. Box 1282, Albany 31703

Dube, Allick M., Internal Med. — MAA — (Active N2), 77 Rockridge Trail, NW, Atlanta 30339

Elliott, L. Franklyn, Plastic Surgery — MAA — (Active), 993-C Johnson Ferry Rd., NE, Ste. 120, Atlanta 30342

Farmer, Timothy L., Internal Med. — Bartow — (Active N2), 962



Joe Frank Harris Parkway, Ste.  
102, Catersville 30120

Igueroa, Ramon-Edgardo,  
Diagnostic Radiology —  
Richmond — (Active), Dept. of  
Radiology, Medical College of  
Georgia, Augusta 30912

Jallen, Johnathan S.,  
Anesthesiology — MAA —  
(Active N2), 4031 Bradbury Dr.,  
Marietta 30062

Graybeal, Frank, Anesthesiology —  
Ware — (Active N2), P.O. Box  
938, Waycross 31502

Greer, Todd B. — MAA —  
(Student), 2617-C Paces Ridge  
Rd., Atlanta 30339

Land, Robert A., Pathology —  
Richmond — (Active), 2260  
Wrightsboro Rd., Augusta 30910

Harper, J. Kel, Obstetrics/  
Gynecology — MAA — (Active  
N2), 993 Johnson Ferry Rd.,  
Building F, Ste. 320, Atlanta  
30342

Hartney, Thomas J., Internal Med.  
— Richmond — (Active), 227  
Thread Needle Rd., Augusta  
30907

Hicks, Winnie C., Internal Med. —  
Bibb — (Resident), Medical  
Center of Central Georgia Box  
88, Macon 31208

Hill, Hank C. — MAA — (Student),  
2909 Campbellton Rd. SW, Apt.  
11-H, Atlanta 30311

Hobbs, Elgin, Emergency Med. —  
Richmond — (Active), Medical  
College of Georgia HA-107,  
Augusta 30912

Holwerda, Dennis L., Pediatrics —  
Dougherty — (Active N2), 525  
Fourth Ave., Albany 31701

Insley, Robert G., Internal Med. —  
Thomas Area — (Active), Doctor  
Park, 930 Fourth St., SE, Cairo  
31728

Johnson, Samuel O., Obstetrics/  
Gynecology — DeKalb — (Active  
N2), 5040 Snapfinger Woods Dr.,  
Ste. 204, Decatur 30035

Jones, Dennis H., General Surgery  
— Richmond — (Active), 1503  
Winter St., Augusta 30904

Jones, Steven R., Pediatrics —  
Richmond — (Resident), 1105  
15th St., #B-2, Augusta 30901

Jones, T. Stephen, Public Health —  
MAA — (Service), 1336 Pasadena  
Ave., Atlanta 30306

Kahan, Joel, Psychiatry —  
Richmond — (Active), Medical  
College of Georgia, Augusta  
30912

Key, Thomas S., Cardiology —  
Richmond — (Active), 1003  
Chafee Ave., Augusta 30904

King, Lisa Y. — MAA — (Student),  
Morehouse School of Medicine,  
720 Westview Dr., P.O. Box 241,  
Atlanta 30310-1495

Kingdom, Todd T. — MAA —  
(Student), 1357 Sheffield Glen  
Way, Atlanta 30329

Klopman, Beth D. Kruse,  
Diagnostic Radiology — MAA —  
(Active), 49 Spring Oaks Ct.,  
Atlanta 30327

Kunz, David W., Family Practice —  
Gwinnett-Forsyth — (Active N2),  
1846 Lebanon Rd., Lawrenceville  
30245

Landstrom, Donald L., Neurology  
— Tift — (Active), 712 East 18th  
St., Tifton 31794

Loebl, Donald H., Rheumatology/  
Internal Med. — Richmond —  
(Active), Medical College of  
Georgia, Augusta 30912

Mitchell, Michael S. — MAA —  
(Student), 720 Westview Dr., Box  
35, Atlanta 30310

Morrison, James P., Pediatrics —  
Crawford W. Long — (Active),  
1010 Prince Ave., Athens 30606

Murray, Andrea J. — MAA —  
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#39, Atlanta 30310-1495

Nealy, Robert J., Gynecology —  
Hall — (Active), 420 Broad  
Street, SE, Gainesville 30505

Newnam, Cheryl L., Internal Med.  
— Richmond — (Active), BD 228  
Division of ID, Medical College  
of Georgia, Augusta 30912

Norman, Brent C., Ophthalmology  
— Richmond — (Active), Dept.  
of Ophthalmology, Medical  
College of Georgia, Augusta  
30912

Pappas, Jamie D., Internal Med. —  
DeKalb — (Active N2), 2030  
Pernoshal Ct., Ste. D, Atlanta  
30338

Pettitt, Barbara J., Pediatric Surgery  
— DeKalb — (Active N1), 1733  
Trotters Lane, Stone Mountain  
30087

Poindexter, James M., Jr., Vascular  
Surgery — MAA — (Associate),  
35 Butler St., SE, Ste. 302, Atlanta  
30355-4001

Quintanilla, Pablo, General Surgery  
— Clayton-Fayette — (Active),  
181-B Upper Riverdale Rd.,  
Riverdale 30274

Ramsingh, Parshan S., Nuclear  
Radiology/Diagnostic Radiology  
— Richmond — (Active),  
Medical College of Georgia,  
Augusta 30912

Rasler, Frank E., Emergency Med.  
— Clayton-Fayette — (Active), 33  
S.W. Upper Riverdale Rd., Ste.  
102, Riverdale 30274

Rodriguez, Rodovaldo, Jr. — MAA  
— (Student), 4203 Buford  
Highway, Apt. E-5, Atlanta 30345

Rogers, Jack A. Jr., Pediatrics —  
Floyd-Polk-Chattooga — (Active),  
1825 Martha Berry Blvd., Rome  
30161

Rogers, Laura Q., Internal Med. —



Richmond — (Active), Dept. of Medicine, Medical College of Georgia, Augusta 30912

Russell, Robert D., Otolaryngology — Muscogee — (Active N2), 6100 Brookstone Blvd., Columbus 31904

Sangster, Joe N. — MAA — (Student), 6800 Peachtree Industrial Blvd., Ste. C-13, Doraville 30360

Scharyj, George A., Internal Med. — DeKalb — (Active N2), 500 Mount Washington Lane, Stone Mountain 30083

Carolyn Seymore, Pediatrics — Richmond — (Active), Dept. of Pediatrics, Medical College of Georgia, Augusta 30912

Shirley, Steve M., General Surgery — Crawford W. Long — (Active), 1270 Prince Ave., Ste. 102, Athens 30606

Shirley, William C., Jr., Obstetrics/Gynecology — Bibb — (Active N2), 380 Hospital Dr., Macon 31198

Shoemaker, Mark M., Anesthesiology — Dougherty — (Active N2), 406 First Ave., Box 1227, Albany 31702

Siegel, Garry E., Obstetrics/Gynecology — MAA — (Active N2), 6500 Vernon Woods Dr., #B-4, Atlanta 30328

Smith, Joy L. — MAA — (Student), 1012 Summit North Dr., NE, Atlanta 30324

Stephens, Augustus T., III — MAA — (Student), 720 Westview Dr., Atlanta 30310

Storniolo, Frank R., Anesthesiology — MAA — (Active N2), 12070 Brookmill Point, Alpharetta 30201

Stubbs, Miguel E. — MAA — (Student), 1178 Piedmont Ave. #6-A, Atlanta 30309

Trytko, Rodney L., Anesthesiology — MAA — (Active N2), 1984 Peachtree Rd., NW, Ste. 515, Atlanta 30309

Vann, David F. — MAA — (Student), 1303 Stillwood Dr., Atlanta 30306

Wagner, Michelle B., Emergency Med. — Richmond — (Active), Emergency Services HA 107, Medical College of Georgia, Augusta 30912

Wagner, Richard G., Jr., Pediatrics — MAA — (Active), Prado East #380, 5600 Roswell Rd., Atlanta 30342

Wilson, Joe E., Obstetrics/Gynecology — Richmond — (Active), 3614-D J Dewey Gray Cir., Augusta 30909

## PERSONALS

### Colquitt CMS

**Nancy LaForte, M.D.**, a recent graduate of Indiana University School of Medicine, has opened a family medicine practice in Moultrie.

### DeKalb CMS

**Family practitioner Omar A. Najjar, M.D.**, was recently elected to the Board of Directors of the Georgia Academy of Family Physicians. He will serve as Director from the Fourth District from 1987 to 1990.

### Emanuel CMS

**James L. Ray, M.D.**, a board certified family physician in Swainsboro, received an American Academy of Family Physicians "Family Practice Teachers Award"

at the Academy's annual meeting last November. The awards are presented in recognition of family physicians who have volunteered at least 75 hours of their time teaching in any area of family practice medicine in 1986.

### Georgia Medical Society

**Savannah surgeon, Roy Powell Barker, M.D.**, was recently inducted as a Fellow into the American College of Surgeons.

### Ogeechee River CMS

**Claxton cardiologist Curtis Hames, M.D.**, was awarded the Georgia Southern College School of Health, Physical Education, Recreation, and Nursing Award for 1987. Dr. Hames was cited for his internationally recognized work in geographically linked cardiovascular diseases.

**Al Mooney, Jr., M.D.**, a Statesboro family practitioner and Director of Willingway Hospital, is one of two physicians appointed by Governor Joe Frank Harris to the newly established statewide commission on drug awareness and prevention.

### Peachbelt CMS

**Daniel E. Nathan, M.D.**, a family practitioner from Fort Valley, has been named volunteer chairperson of the Peach County Campaign for Excellence for the Mercer University School of Medicine in Macon.

## DEATHS

### Floyd-Polk-Chattooga CMS

**Robert M. Harbin, M.D.**, of Rome died last October at the age of 84. Dr. Harbin had retired



from his practice of medicine and general surgery at the Harbin Clinic in June, 1975, ending 45 years of service.

A graduate of Darlington School, the University of Georgia and Emory University Medical School, Dr. Harbin interned at Peter Bent Brigham Hospital in Boston.

In addition to his state and national medical association memberships, Dr. Harbin was a Fellow of the American College of Surgeons. He was also involved in community and church activities, serving as a Board member and trustee, respectively.

Survivors include his wife, two daughters, four grandchildren, and several nieces and nephews.

## Georgia Medical Society

**Ralph Marsicano, M.D.**, a family practitioner in Savannah, died in June of 1987.

Dr. Marsicano was born in New York City and began his medical education by graduating from Long Island University and Duke University's medical school. He continued his medical education by postgraduate training in Richmond, Virginia, and New York City. During World War II, he served with distinction in the U.S. Army Medical Corps and was promoted to the rank of Major.

After the War he established a family practice in Columbus, Ohio. In 1975, he moved to Savannah where he opened a new practice.

Dr. Marsicano is survived by his wife, and two sons.

**Wilbert Otho Brown, M.D.**, died last June in Savannah after a short illness.

A native of San Bernito, Texas, Dr. Brown received his undergraduate and medical degrees from the University of

Texas. He served his internship in Pittsburgh and his residency at the University of Illinois Medical School in Chicago where he taught for 7 years. He was a faculty member at Baylor University, and later went into private practice working for 32 years in Pueblo, Colorado, and Scottsbluff, Nebraska, using his hobby of flying to facilitate a multiple clinic practice.

After a long and distinguished career, including the publication of numerous medical articles, he retired and moved to Savannah in 1979. Not content to dissociate himself from medicine, he immediately joined the Georgia Medical Society and actively participated in the Society's activities and meetings.

## Muscogee CMS

**Columbus internist McLeod Patterson, M.D.**, a native of Alabama died last October at the age of 72.

Dr. Patterson graduated from the University of Florida, at Gainesville, and then from Tulane University of Louisiana Medical School. He served a rotating internship at Charity Hospital in New Orleans in 1940, following which he started an internal medicine residency which was interrupted by the outbreak of World War II. He entered the Army in 1941, and spent the entire war as physician on troop transports, making 44 roundtrips between the U.S. and Europe, on this very hazardous duty, in which he attained the rank of Lieutenant-Colonel.

Thereafter he resumed his residency and entered practice in Somerset, Kentucky in 1949.

Dr. Patterson came to Columbus in 1966 as director of medical education at Medical Center

Hospital where he directed the opening of the first coronary care and renal dialysis practice, serving on the staffs of St. Francis and Medical Center Hospitals until semi-retirement in 1983.

He is survived by his wife, daughter, two sons, and four grandchildren.

## QUOTES

*At the base and birth of every great business organization was an enthusiast, a man consumed with earnestness of purpose, confidence in his powers, and faith in the worthwhileness of his endeavors. The original Henry Ford was the quintessence of enthusiasm. In the days of difficulties, disappointments and discouragements, when he was wrestling with his balky motor engine — and wrestling likewise with poverty — only his inexhaustible enthusiasm saved him from defeat.*

B.C. FORBES

*Do men like to fish or do they just like to get away from it all?*

WILLIAM FEATHER

*There's lots of people in this world who spend so much time watching over their health that they haven't time to enjoy it.*

JOSH BILLINGS

*Be gracious to all men, but choose the best to be your friends.*

ISOCRATES

*Fidelity bought with money is overcome by money.*

SENECA

*I am a great friend to public amusements, for they keep people from vice.*

SAMUEL JOHNSON





*U.S. Senator Wyche Fowler*

## An Interview With U.S. Senator Wyche Fowler

*Ed. Note: The following interview was conducted in U.S. Senator Wyche Fowler's office in Atlanta on September 21, 1987. In attendance were the Journal's editor and managing editor; James A. Kaufmann, M.D., Chairman of MAG's Council of Legislation; and Steve Davis, Ph.D., MAG's Director of Education.*

**MAG:** *Senator, why don't you tell us how you got here? You know, it's always fascinating to see somebody like you, who starts off in a local political environment like Atlanta, and goes to the Congress and to the United States Senate. You begin to ask yourself, "Where's this guy going to stop?" Are you happy where you are?*

**SENATOR FOWLER:** First of all, I'm stopped! [Laughs.]

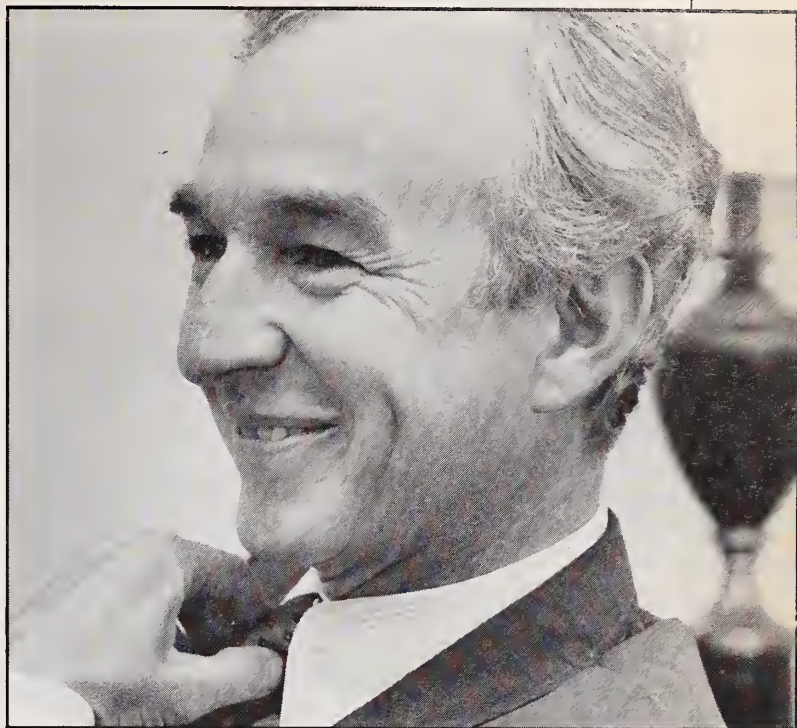
I'll try to ramble a little bit, in no special order.

I was in the Army in 1964-65, in Army Intelligence. I had just come out of the infantry, and I was assigned to the Pentagon, when those little girls were killed in the Birmingham church bombing. The Congressman from Atlanta, Charles Weltner, whom I had never met, took the floor of the House that morning and said that we all share blame for this kind of thing because those who have been elected to lead have failed to lead, and that if racial prejudice is going to be dealt with, it had to be confronted by all of us, especially the elected officials in the South.

When I read this — it was on the front page of the *Washington Post* — I just picked up the phone, called him up, and told him that I was an Atlantan, that I was proud of him as a Georgian, and that I would like to meet him sometime. So he invited me over for a cup of coffee. The next thing I knew, I got out of the Army 6 months later and took over as Congressman Weltner's chief of staff. That's really how I got into politics.



**“Physicians are one of the few professional groups who receive tremendous respect and trust before they practice their profession. . . .”**



**T**hings sort of moved fast after that. I was with Congressman Weltner for 2 years, until he resigned his seat in Congress on a matter of conscience in 1966. By then I was 27 and had been supposed to go to law school. So, I came home for the first time in nearly 10 years and went to Emory.

About the fourth quarter I got a little antsy. Everett Milliken was retiring from the City Council. I had Congressman Weltner's district-wide mailing list, and of course I knew a lot of people through him. Also, I had all of that "free labor" out there (what they call students). So 14 of us from Emory Law School ran a city-wide campaign for less than \$4,000. I called myself an urban consultant, rather than a student. You know, it used to be that if someone came around with a card that said "consultant," you knew they were unemployed. But now a "consultant" is the fanciest thing you can possibly be!

**MAG:** *Before your election to the Board of Aldermen, weren't you also ombudsman and night mayor?*

**SENATOR FOWLER:** That's right, while I was in law school. One night I called down to Mayor Ivan Allen about 5:30, and I got this recording at City Hall. I had known Mayor Allen through Charles Weltner. I couldn't believe that I used to work in Congress until 9 or 10 o'clock every night, but nobody was at City Hall at 5:30! I thought it was terrible. I went down to see Mayor Allen, and I said, "Look, you can't have those people working out in the streets, waitresses, carpenters, people working shifts that have legitimate business at City Hall, not getting through on the phone. You can't act like it is some corporate office and work 9 to 5. Somebody has got to be down here at least to answer phones and be polite to people and take messages for the next day."





*Dr. Charles R. Underwood, JMAG editor*

He said, "That's a great idea! What damn fool can we get to stay down here?"

Says I, "You're looking at him."

**MAG:** *Weren't you also called "night mayor" of Atlanta?*

**SENATOR FOWLER:** Well, there wasn't that much to do. When the reporters came down to City Hall and asked, "What are you doing down here?", I sort of fudged a little bit and said, "Well, I'm sort of a 'night mayor.'"

So the next morning's headlines read: "Night Mayor Runs the City." Ivan Allen called me the next morning and said, "You trickster! What have you done? What are you running for?"

I had one of those Ralph Nader unsafe-at-any-speed Corvairs, and I just put a little sign on it — my only billboard when I was running for Alderman — and the sign just said, "NIGHT MAYOR RUNS FOR ALDERMAN." I'd take it and park it at Lenox Square and let it sit there for 2 or 3 days and everybody would see it. Then I would move it to another shopping center.

But that was really the secret of my first election — an unelected public office and a moveable billboard!

**MAG:** *Is there a question that you would like to be asked in an interview that you rarely if ever are asked?*

**SENATOR FOWLER:** Nothing comes immediately to mind, but I do enjoy most interviews conducted by students. I spend a lot of time on college campuses and at high schools talking with students because I enjoy their straightforwardness and their insights. They ask tough questions.

When you speak to civic clubs, adults are much more worried about what people think of their questions than about what the answer is going to be. Sometimes they become very predictable.

**MAG:** *You went to Davidson, is that right? The college has graduated a lot of preachers. How did you avoid becoming one?*

**SENATOR FOWLER:** I did think I was going to be a minister all through high school. I grew up attending Second Ponce De Leon Baptist Church under Dr. Monroe Swilley, who was a great influence. I won a couple of little speaking contests when I was in Sunday School when I was 13 or 14. Then the statewide Community Chest put me on the circuit, speaking on behalf of the Community Chest when I was 15, so that I moved around the state, mostly speaking in churches and Sunday schools, things like that.

I went up to Davidson with my father and liked the school. A lot of Atlantans were going up there at that time; people at Northside and Westminster. When I went, coming out of high school, I





*The Senator's enthusiasm was wonderfully infectious. Shown here (L-R) are Dr. James Kaufmann, Chairman of MAG's Council on Legislation; Dr. Charles Underwood, Journal editor; Senator Fowler; Susan Dillon, Journal managing editor; Steve Davis, Ph.D., MAG's Director of Education.*

did think that I wanted to study the ministry. But the good Lord obviously had other plans.

**MAG:** *If one follows your career, you've shown that you have an interest in people. In political terms, you've been known as a liberal. Do you like that image, or do you think you have it? Does it bother you that people talk about Wyche Fowler being a liberal?*

**SENATOR FOWLER:** Yes, it bothers me, because the term is now used only as a taunt — it is not descriptive. Your opponents believe that's the worst thing they can say about you. They try to put you in a box and label you. They fear it will be libelous if they call you a "communist" or a "socialist," so they say you are *liberal*, and that is supposed to conjure up all the most undesirable traits that Georgians would reject in their politicians.

That was the foremost tactic used against me in my statewide race for the Senate, and it was not very subtle both in the television advertisements and in innuendoes all over south Georgia. My opponents would simply say, "Fowler is this liberal representing all those blacks." You get the message.

But thank goodness people are a lot smarter than that. I feel like I've been washed and cleansed by the voters of Georgia. They dismissed the labels and voted for the man.

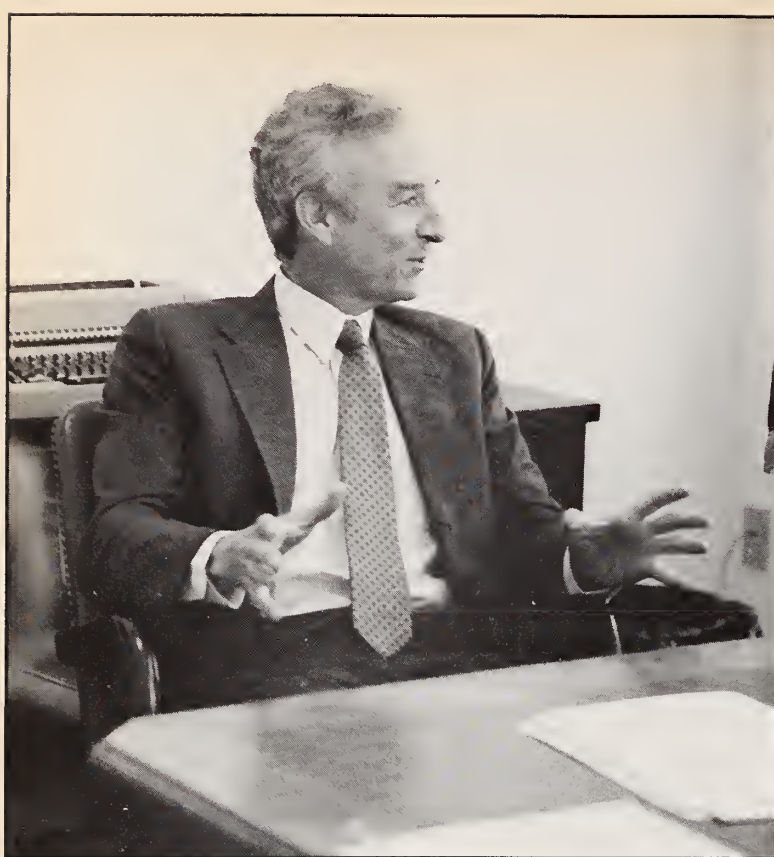
**MAG:** *You used the words you thought that people in Georgia had washed you clean or something like that. . . .*

**SENATOR FOWLER:** Well, every time you put your name on the ballot and give up the office you have, then go into the fire, you don't know whether you will be consumed or whether you will emerge victorious. In the Congressional races, there are no free shots. You have to give up what you have to achieve what you might become. I have always liked our system, because that puts you in the hands of people, and they understand that you've put it all on the line, that your fate is in their hands. And that is what creates the partnership between those who elect and those of us who are elected to serve them. You have got some positions in the state where incumbents can take "free shots" and yet keep their seats if they lose. That's not putting it on the line.

**MAG:** *During the Iran-Contra hearings, George Schultz made the remark that if you want a job so badly that you are not willing to give it up, you really can't do it well, or something to that effect. Do you think this is an important statement?*

**SENATOR FOWLER:** Yes. People have different views of public life. I happen to believe that public service is really unlike any other job in





***“In the Congressional races, there are no free shots. You have to give up what you have to achieve what you might become.”***

our private enterprise structure, in that all of your authority and your power is drawn from the citizens. If you believe in this Constitution of ours, the *people* are the government in this country. It's not some detached body; that's the sort of mystical part of our democracy. The elected have got to know that we are serving under your authority and that you are the ones that confer the office.

Therefore, if you trust people — which admittedly many politicians don't — but if you trust them to make the right decision, or the better decision between candidates, the citizens pick that up. They can see clearly those who trust them and who are willing to place one's destiny, one's fate, in their hands, and those who are removed from them and distrustful of them.

I have been very fortunate. People have been extraordinarily good to me. They know that not only am I not afraid of them but also more importantly, they sense that I am comfortable with them, because I get my strength and my reservoir of energy from them. I call it an “umbilical bond” between the voter and those who seek to serve.

**I** have no idea whether I am “liberal” or “conservative.” If it is liberal to want to conserve the land and to have the cleanest air and the cleanest water, to worry about toxic pollution of ground water for our grandchildren, to try to conserve policies that will insure the finest quality for our nation's health — if that is liberal, then I guess I'm liberal. If it is conservative to make sure that the Defense Department does not spend \$180,000 for coffee makers, or \$8,000 for widgets, then I am very conservative.

My chief confession is that I'm very old-fashioned. I understand that, and people who watched my campaign understand that, because I rejected most technology. I rejected the advice of experts, including all the experts who advised me not to run because I couldn't win. And then I just trusted the people, going in a very old-fashioned way from county to county, community to community, and talking about where I thought we could do a better job in the Congress: education, our nation's health, how we create jobs in a very competitive international market. In all the things we used to sell in the South, like cheap wages and unlimited use of water and forests, we have been outbid by the Taiwanese and the Koreans. They say, “If you will come over here, we will give you cheaper wages and more unlimited timber and water, and we're not going to put any environmental controls on you.” So the jobs have moved away. I just think that we can come up with a lot better policies and go to work.

**MAG:** *You like to read fine old novels, such as Anthony Trollope, and perhaps a little poetry now and then. Where do the arts fit into your life or into your political views?*

**SENATOR FOWLER:** My education was a simple liberal arts education. My majors were English and philosophy. I believe in the value of education as not only the best guide to living but also living well. I don't go around quoting Trol-



lope or Yeats in my speeches, but it beats reading the budget!

I had a professor in law school, a wonderful fellow named Tarver Rountree. When I wrote up my little announcement that I was going to run for office, I took it in to him. I had spent some time in Ireland following Yeats, who is a great hero of mine, around his country — the Galway coast, his bars and taverns, and where he is buried. One of his fine poems is called "An Irish Airman Foresees His Death." The ending goes something like, "Those that I guard I do not love / those that I fight I do not hate. / Only a lonely impulse of delight / led me to this tumult in the clouds. . . ." So in my press release I had written that one of the reasons I was running was "a lonely impulse of delight."

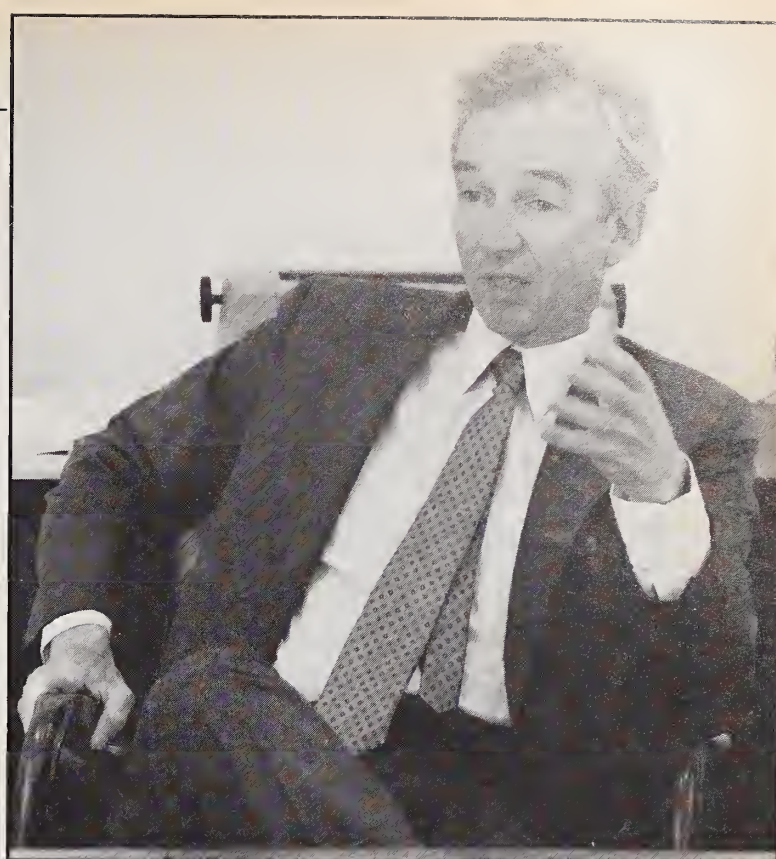
Professor Rountree read it, but he was strangely silent. I said, "Come on, tell me what you think." He said, "No, it's fine. I just have one suggestion." Of course, very smugly I knew what it was, but I said, "Well, what is it?" He said, "Wyche, I just believe that if you're going to have a future in politics in Georgia, I hope that this is the last time you match subject and verb."

Anyway, he didn't mess with the Yeats.

**MAG:** *Do United States Senators play baseball on the Mall near the Capitol? You are a baseball player; what advice would you give to Ted Turner to help the Braves?*

**SENATOR FOWLER:** I'd give him plenty of advice, but unfortunately it all has to do with the size of his checkbook. They have a Congressional softball team; my office has a team that plays on the Mall, but I quit doing that 3 or 4 years ago. I have been dragged kicking and screaming into middle age. I'm now protecting my rotator cuff.

**MAG:** *Let's talk about morality. As physicians, we are concerned with some of the public's thinking that they can't trust us, or the govern-*



**“I believe the medical profession represents an extraordinary gift of public trust.”**

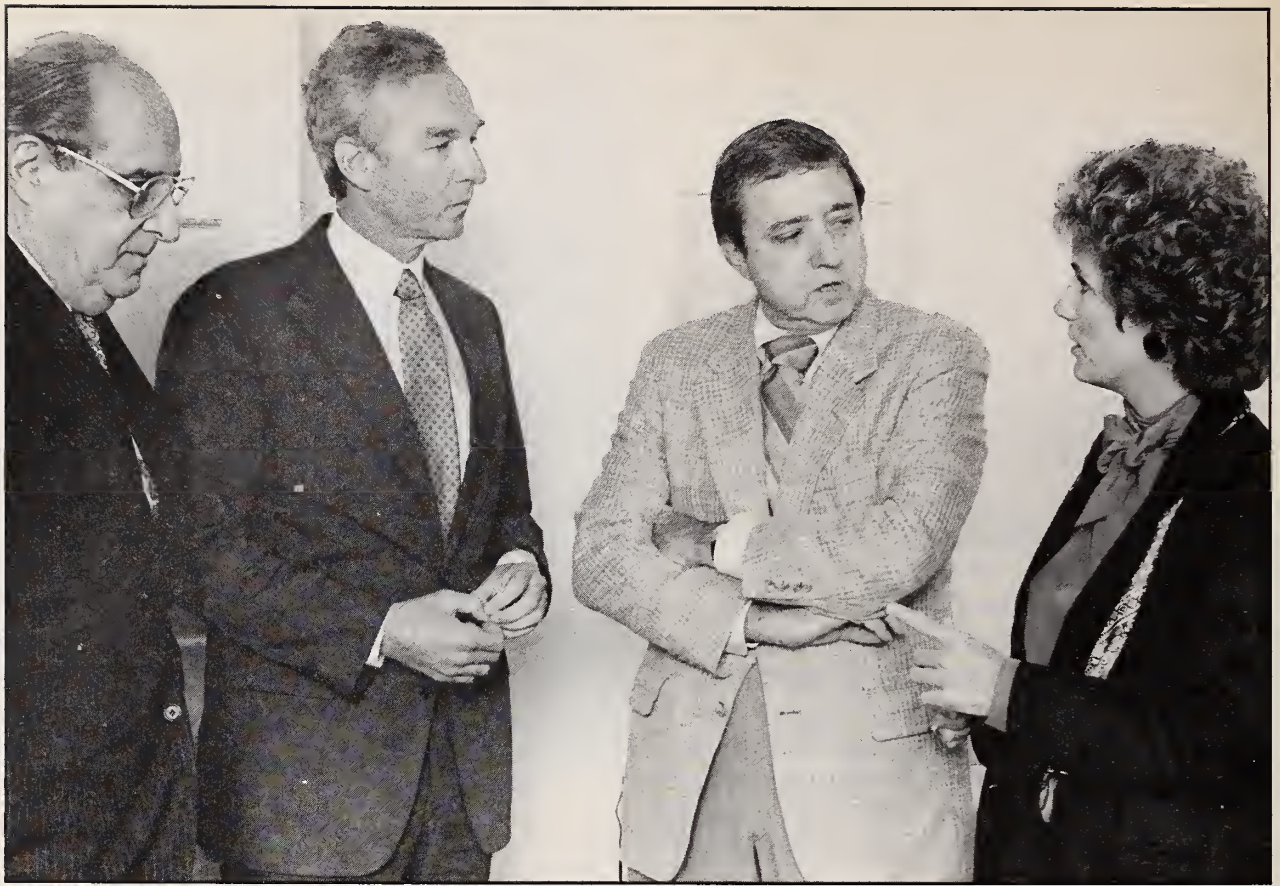
*ment suggesting that it can't trust our sense of fiscal responsibility. What do you think? How do you look at our profession? Do you as an outsider from medicine worry about the state of ethics in organized medicine?*

**SENATOR FOWLER:** Well, I don't have all those answers. Let me just say this. I believe that the medical profession represents an extraordinary gift of public trust. It is one of the highest callings in our society — the calling to heal and to comfort the afflicted. I must say I have certainly been impressed over the years by the quality of the men and women who enter medical service at all levels, from nursing to doctoring.

I have a long-term, sustained interest in health care, because I know instinctively how difficult and challenging the demands on the profession are. A lot of these so-called "moral" questions are going to get tougher and multiply as the population ages and increases, and as the combination of science and technology forces a re-examination of traditional practices by the medical profession.

The primary thing that anybody over 60 years old is concerned with 90 percent of the time is





(L-R) Dr. Kaufmann; Senator Fowler; Dr. Underwood; Ms. Dillon.

health care: how legislation affects them, whether or not prescription drugs come from Medicare, whether or not they can get better artificial limbs from the Veterans Administration. Then there are even more difficult questions that I believe are inappropriate for the legislative domain: questions of when life begins, when it ought to be terminated, under what circumstances? These are really ethical questions; they are theological and medical questions. They should not be, in my opinion, decided by legislative bodies.

On the questions regarding individuals and their own health and how they feel about themselves — and when they are hurt who they will go to to heal them — I want to keep those questions to the greatest possible extent between the doctor and the patient. I don't want the government circumscribing precisely the manner, place, or the technique of treatment.


**MAG:** *How about telling us anything else that's on your mind that you want us to tell the doctors in the state of Georgia.*

**SENATOR FOWLER:** I don't know that I have any great message except one of respect, as I have already indicated. I am pleased to see more and more doctors assuming positions of responsibility and leadership in their communities — outside of the medical profession. Physicians are one of the few professional groups who receive tremendous respect and trust *before* they practice their profession, just by having the term M.D. after their name from the moment they graduate from medical school. They are given an inordinate amount of public trust and responsibility before they have had the opportunity to earn it. And if they realize that and guard that trust, then I think they would be surprised how their influence will be felt on all other matters of human endeavor in which they are naturally interested as citizens.

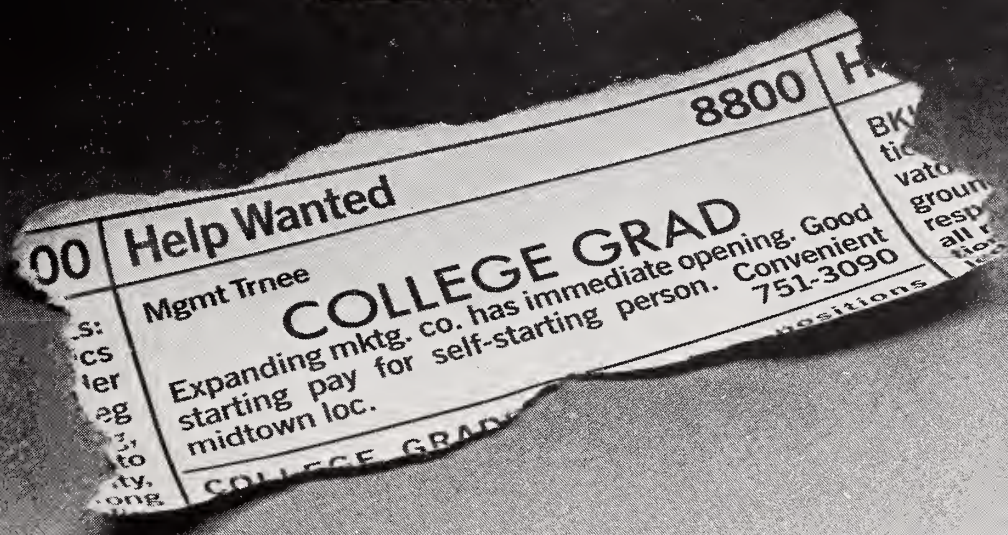
**MAG:** *Senator Fowler, thanks for your time.*

**SENATOR FOWLER:** I've enjoyed it. But watch out — this *Journal* interview will probably cause some subscription cancellations! [Laughs.] ■





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**Indications:** Yocon<sup>®</sup> is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

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**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

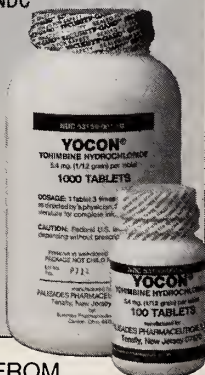
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon<sup>®</sup> 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
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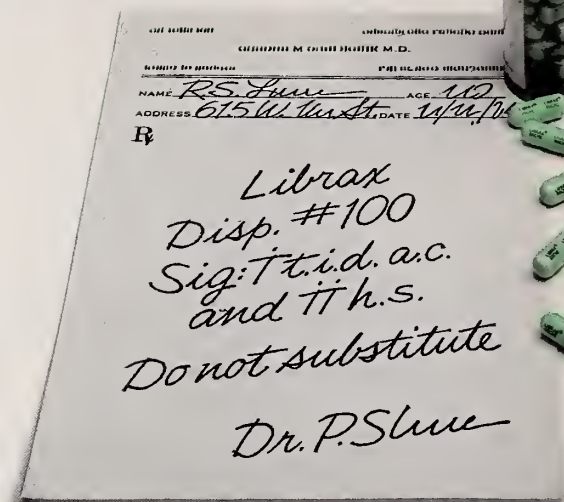
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Please consult complete prescribing information, a summary of which follows:

- \* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows: "Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis. Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium<sup>®</sup> (chlordiazepoxide HCl/ Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

**Use in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur. **Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

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\*Librax has been evaluated as possibly effective as adjunctive therapy in the treatment of peptic ulcer and the irritable bowel syndrome.

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# Points of View:

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**T**he emergence of the drug repackaging industry as well as the new Rules of the Georgia State Board of Pharmacy have generated much debate about the dispensing of drugs by physicians. These issues will likely be addressed at the 1988 Georgia General Assembly, though as of this printing, we do not know what, if any, legislation will be introduced. Presented here are two opinions on the issues: one from a physician representing his group practice and the other from a pharmacist and the Executive Director of the Georgia Pharmaceutical Association.

## Point: The Physicians' Experience

W. Scott James, M.D.

**“We have been dispensing medications from our office for just over one year, and as our poll predicted, we have had excellent acceptance and appreciation for this service from our patients.”**

**T**HE HORSE-AND-BUGGY days of practicing medicine have long since disappeared and are almost forgotten, except for those who venture to Jefferson, Georgia, and visit the Crawford W. Long Museum. While roaming through this historically rich museum, one can imagine the country doctor of the past visiting his patients at home and dispensing various medications out of his large black bag.

Eventually, of course, apothecaries sprang up around the countryside, staffed by pharmacists who were trained in the art of using their mortar and pestle for mixing complicated medications, carefully following the doctor's instructions scribbled on a piece of paper — usually in Latin. In rural areas, some physicians continued the dispensing of medication, but in urban areas where pharmacies became more abundant, the physician left the timely mixing and dispensing of drugs to the pharmacist, who op-

erated in a store stocked with numerous medicinal ingredients.

Over the years, modern pharmaceutical research and industrialization removed much of the mystique of the mortar and pestle, substituting for them multi-colored capsules, enteric coated tablets, syrupy liquids, and powdered antibiotics that are the products of today's large pharmaceutical houses. As a result, the pharmacist's function changed. No longer a compounder of original medicines, the druggist became primarily a keeper of packaged medications. While the physician might have with him a dozen or two pharmaceutical agents, the pharmacist kept on hand a multitude of drugs in varying dosages, ready for dispensing whenever the physician prescribed. Not surprisingly, the number of physicians who dispensed has dropped dramatically. In the 1940s, perhaps 25% of practicing physicians in the United States dispensed drugs. This number fell to 10% by 1967; it is even smaller today.

At the same time, rapidly advancing medical technology, in-

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Dr. James practices pediatrics in a six-man group and serves on MAG's Ad Hoc Committee on Physician Dispensing and Drugs. Send reprint requests to him at 993-D Johnson-Ferry Rd., Atlanta, GA 30342.

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*Continued on p. 32*



# Physician Dispensing of Drugs

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## Counterpoint: The Pharmacists' Experience

John T. Sherrer  
Larry Braden

***“As pharmacists, we believe that it is our responsibility to ensure that this safety net is maintained for the good of patients and that medical practitioners dispensing be extremely limited.”***

SINCE THE VAST MAJORITY of us who are practicing medicine or pharmacy in this country received our education here in the United States with its Western-European history, we tend to think of Hippocrates when asked about the origin of the practice of medicine. Hippocrates and his fellow Greek intellectuals sought rational explanations of everything. Their best writings and practices established the fundamentals of the scientific method and began the process of the rejection of unsupported theory and superstition, thereby paving the way for today's rational and extraordinarily effective health care system.

Pharmacy and medicine were essentially one in the same from the earliest recorded history until the 13th century when most historians feel that the two professions had evolved to the point that health legislation was enacted in the Kingdom of the Two Sicilies that pro-

vided for the separation of pharmacy from medicine. That legislation established official supervision of the practice of pharmacy and obligated the pharmacist by oath to prepare drugs reliably, according to skilled art, in a uniform, suitable quality. Through the ensuing centuries medicine and pharmacy have evolved separately but always in tandem, providing today's patients with a vast array of pharmaceutical products, the expertise of highly skilled physicians, and the expertise of highly skilled pharmacists. Today's physicians can prescribe for their patients' needs from an armamentarium of some 3000 drugs stocked by the typical pharmacy. Physicians can call upon the pharmacists' experience and unique knowledge gained by some 6-7 years' academic training to assist in determining available and appropriate product forms and dosages in virtually any variation or combination necessary to provide their patient with optimum therapy.

During the last couple of decades, pharmacists and physicians

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Mr. Sherrer is a pharmacist, and Mr. Braden is Executive Director of the Georgia Pharmaceutical Association. Send reprint requests to Mr. Sherrer, 833 Campbell Hill St., Marietta, GA 30060.

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*Continued on p. 33*



creasing urbanization, and changes in America's lifestyles have not only made it possible but almost obligatory for the primary care physician to add new services to his or her office practice. We are now performing many more laboratory and testing services for our patients than we did 20 years ago — throat cultures, rapid latex strep tests, urine cultures, CBCs, aminophyllin levels, etc. — which save the patient time, energy, and expense, as well as give immediate results. Convenience and good patient care are thus assured.

**T**he same motivations of good patient care and convenience spawned another service that physicians are performing in their offices today. Several years ago, drug repackaging houses sprang up around the country offering physicians the choice of medications to dispense from their offices. Presently, some two dozen pharmaceutical repackagers serve physicians, veterinarians, podiatrists, and dentists who wish to dispense as well as prescribe drugs.

**“... there needs to be separate rules and regulations governing the dispensing physician, applicable to the office setting, which by nature of its operation is not akin at all to the pharmacist's setting.”**

When approached by one of these companies for the purpose of dispensing in our pediatric office, my partners and I initially gave a negative response. Later, however, we took a poll of our patients and were somewhat surprised by the overwhelming (90%) positive attitude of our patients concerning office dis-

persing. I have since learned that other groups have taken polls of their patients and have had similarly positive results. Our poll indicated that our patients' parents favored office dispensing of medications largely because of the convenience for them, and the fact that they would not have to spend from 20 to 60 minutes from the time they left our office to get the medication until they arrived home with their sick child. A total of 24% of the respondents felt that the price might also be a factor in deciding to get their medications from our office. By and large, the parents did not want to have to take a sick child (especially two or three) through traffic, wait for the prescription to be filled, and then finally get home before the first dose of medicine was administered.

**W**e have been dispensing medications from our office for just over one year, and as our poll predicted, we have had excellent acceptance and appreciation for this service from our patients. We would not have started this new service for our patients had they not overwhelmingly favored it. As in years gone by, this is seen as a service and convenience by our patients from their physician. Every time we dispense medication, it does take some extra time, but it is well worth it. We simply let the parent know that this is available if they choose to use it, and those who have used the service previously, usually ask “Do you have this medicine here in your office?” Many times we do not have a particular medication that we want to prescribe, and therefore we write many prescriptions each day. The fact that we dispense medications has *not* in any way changed our method or choice of prescribing. In reviewing our charts, I have noticed that *none* of us in our group of six pediatricians has been prescribing more medications since we started dispensing. In other words, in our experience, our practice of medicine remains the same, except that we offer a new service in our

office. Additionally, our prices for the medications to our patients have not increased since we started dispensing in October of 1986 — in fact in two instances the price has decreased. The slight increase in cash flow from dispensing has offset to some degree our increased overhead during the last year.

Some of the unexpected rewards from office dispensing have been noted in expressions of gratitude from our patients' parents in having this service available for them — usually from the convenience of not making an extra trip with a sick child to get their medications prior to returning home. Several mothers have exclaimed to me “Why haven't you been doing this (dispensing) before now?”

**G**ood patient care and convenience also involve not only the obtaining but also the administering of the medication. Those of us who have been in practice for 20 years or more will sometimes reminisce on the numerous house calls that we made prior to going home for supper, and the injections and medications that we dispensed at the bedside. The patients appreciated the convenience of our demonstrating the proper use of eyedrops or eardrops in a squirming child. No lengthy directions on a label of eyedrops or advice from a well-meaning pharmacist could ever take the place of a mother's own physician helping her with her baby — especially if this first-time mother had never seen or helped anyone do this before. We have had mothers tell us on a return visit that they certainly appreciated our putting eardrops in the child's ears while on the examining table, giving him his pain medication, and administering the first dose of the oral antibiotic prior to leaving the office. In each instance, the child felt better by the time they had arrived home, and the mother knew that the antibiotic was already working on the infection.

*Continued on p. 34*



have increasingly worked closer together in both the community and the institutional setting where pharmacists play key rolls in P & T decisions, provide specialized hi-tech preparations for patients, and with increasing frequency make rounds to assist the attending physician in selecting and monitoring appropriate drug therapy. In the nursing home environment, pharmacists have assumed, under federal requirements and guidelines, increasing roles designed to assist the attending physician and nursing staff in monitoring rational and cost-effective drug therapy.

Never a day goes by in the normal practice of community medicine and pharmacy that the physician and pharmacist don't interact on behalf of the patient. Whether it is the simple, routine call from the pharmacist to check for an OK on a refill, or the occasional life-threatening prescriber error or drug interaction, pharmacists and physicians have been a close team with tremendous benefits for our health care delivery system with surprisingly few instances of friction or misunderstandings.

If the system has evolved so logically and is working so well, then why is this current controversy swirling around physicians selling drugs for profit, a controversy that has even led to congressional proposals to outlaw the activity?

The answer can be found primarily in the emergence of a new "growth industry," the so-called repackaging industry, which is directed towards capitalizing on some of the basic economic principles of our nation's drug distribution system but, in the eyes of pharmacists and many others, at the ultimate expense of patients and our high-quality health care delivery system.

What is a repackaging house? Repackagers are companies which obtain a federal license to purchase drugs in bulk quantities and then repackage them into smaller containers with appropriate relabeling. Recognizing that the

universal "80-20" rule of economics exists in pharmacy operations as in virtually every other industry, the majority of gross revenue, i.e. 80%, will be generated by less than 20% of the existing inventory. Conversely, more than 80% of the items carried by the typical pharmacy create less than 20% of revenue. But it is those items which provide the physician with the broadest range of therapeutic alternatives available to any medical practitioners anywhere in the world. It is those products which are infrequently used by the typical practitioner, occasionally needed by the atypical patient, the products which pharmacists maintain for the benefit of the physician and the patient. Frequently, it is in areas of medical practice dealing with those infrequently used products that the pharmacist and physician find themselves interacting on a personal basis in order to help a patient.

Repackagers, however, would lead physicians into disregarding any thought about the ultimate effect on our total drug distribution system in exchange for the lure of promises stating that you can expect "thousands of dollars added to your bottom line" if you, the prescriber, will only choose to capitalize on the system, sell the drugs you most frequently prescribe, when it is convenient for you, and leave the night, emergency, weekend, and expensive, less profitable drugs for your patients to acquire from their pharmacist.

By any reasonable definition, this situation, which has been created largely by the profit motives of repackagers enticing physicians to lay aside traditional concerns about ethics and their responsibilities within the entire health care delivery system, causes grave concerns in the minds of many persons about the conflict of interest which is created when a physician sells drugs for profit.

Three prominent medical spokesmen have recently cau-

tioned their colleagues against physician drug sales. Dr. Arnold S. Relman, editor of the *New England Journal of Medicine*, recently wrote Congressman Ron Wyden (D-OR), who has introduced legislation to prohibit prescribers selling drugs for profit. In his letter Dr. Relman stated, "I favor your bill because it supports the basic ethical code of the medical profession and helps to counter forces that lately have been commercializing the practice of medicine. Any arrangement that encourages doctors to become vendors of drugs they prescribe creates conflicts of interest that tend to weaken the role of the doctor as the patient's agent and trustee."

**“The legal requirements and professional standards for record keeping, labeling, and dispensing which pharmacists must adhere to are well founded in good patient care.”**

During an interview on ABC's "Good Morning, America," AMA Trustee Dr. Robert McAfee commented, "We think this is not in the best interest of patients — for doctors to participate in that kind of endeavor on a regular basis. Certainly in those areas where ethical pharmacists and suppliers of devices are available to patients, we don't think that physicians on a regular basis should participate for profit."

During that same interview, ABC Medical Editor Dr. Timothy Johnson agreed with McAfee: "I do have an objection (to physicians selling

*Continued on p. 35*



**C**ompliance is an important part of prescribing medication, and if one dispenses in the office, one is sure of the initial compliance and usually sure that the child will get the medication as directed, since the medicine is already in the mother's possession.

Since we began dispensing, a national study has been released that confirms our experience. A report presented at the Rutgers University Pharmaceutical Conference last June showed that noncompliance — patients failing to have their prescriptions filled and failing to take medications as directed by the physician — was a major health problem in this country, leading to lost work days, unnecessary hospitalizations, and as many as 125,000 deaths annually. Physician dispensing not only ensures the filling of the prescription but it also improves the patient's compliance with the physician's instructions. The Rutgers report indicated that while only 43% of the respondents could recall a pharmacist giving them instructions, fully 92% remembered how their doctor gave them detailed directions on dosage at the time they received the prescription.<sup>1</sup>

## **“Office dispensing affords greater convenience and compliance for our patients.”**

In our practice, we have had several instances prior to our dispensing where a parent would call us at 7:00 o'clock at night complaining of a high fever after the child had been in the office earlier in the day. Our response was that the antibiotic had not had a chance to work as yet — especially when we learned from the mother that the father had just gotten home from work, and the baby had not received the first dose — 6 hours after

being seen in the office. When we dispense medication to our patients, we hand it to the parent and verbally give her or him instructions as we point to the label. If the parent has any questions at that time, she or he can ask us directly. We also have the child's chart in front of us and thereby know if he or she is allergic to certain medications, does not take one brand or generic as well as another one, or any other idiosyncracies that might apply. We are all human and are subject to mistakes, but this system seems more fool-proof than any I know.

One other beneficial spin-off from office dispensing is that we can be certain of the generic drugs our patients may be receiving. However, when we prescribe a drug, we are familiar with its action, but we have no knowledge of the therapeutic rating or manufacturer of a generic that may be substituted by a pharmacist. It is important that we know which generic our patient is getting — especially in light of the new generic prescription law that went into effect last October 1.

**I** also wish to point out that before beginning to dispense drugs in our office, we studied the state statutes concerning the dispensing of medicines. It is only natural that rules and regulations be in place to control the quality and to standardize the dispensing of medications. If a physician dispenses medication from his own office, there is no pharmacist or other third party involved, and we are essentially back to the “black bag” days where the physician, trained in disease, pathology, diagnosis, and treatment, is able to decide which medicine his or her patient needs. He or she therefore handles it in a more direct manner without actually writing a note to a third party saying what the patient should receive. Our nurses are trained in medication doses, and we rely on them to draw up Demerol, antibiotics, and other medications in a syringe, and administer them to our patients directly. We can also entrust to the same nurse the job of helping us

add water to powder in a pre-measured bottle in order to make a suspension. The physician must have direct control of the whole operation and must hand the medication directly to the parent or patient with some verbal instructions as well as written instructions. And as they do with their medical records, physicians should keep an accurate account of the drugs that are dispensed in the office. Under these circumstances, it would seem redundant to require the practicing physician to be under the very same rules and regulations which apply to a pharmacist.

But the point here is that there needs to be separate rules and regulations governing the dispensing physician, applicable to the office setting, which by nature of its operation is not akin at all to the pharmacist's setting. The Composite State Board of Medical Examiners, which governs the practice of medicine in this State, should address this situation and formulate new rules that would pertain to the dispensing physician. This situation can be handled effectively by the Composite Board, and I am sure that dispensing physicians would welcome such a move.

**O**ffice dispensing has been a learning experience for us in many ways, has brought us closer to some of our patients — improving the doctor-patient relationship — and has been appreciated by almost all who partake in it. Our experience with dispensing has been a very positive one, both for the patient and the physician. In this article, I am only relating how dispensing evolved in our practice, and what results we have obtained so far. We certainly do not expect that all physicians would either feel the need for or want to initiate this service in their offices, but it is a service that should be understood and evaluated for the possible benefits to all.

### **Reference**

1. Robbins J. Noncompliance costs pharmacies billions. *Am Druggist* July 1987.



drugs) if they are sold at profit." He said, "I think that when a patient comes to a doctor, there should be no question that the doctor is there to serve in an overall advisory role, not as a vendor of drugs or products."

**A**s pharmacists, we strongly oppose the practice of medical practitioners dispensing prescription medication to their patients. Physicians are experts in diagnosing health problems and in prescribing therapy, while pharmacists are experts in ensuring the rational use of drugs and in communicating that information to patients and other health care professionals.

We believe strongly that all patients receiving medications are entitled to comprehensive pharmaceutical services including, but not limited to, maintaining patients' medication profiles, i.e., complete manual or computer records of all drugs taken by the patient, and counseling patients. These essential elements of patient care are sacrificed when medications are dispensed by medical practitioners. Few patients have a single physician. Every pharmacist can cite numerous examples of drug interactions that have been avoided by the intervention of the pharmacist when a patient is referred, or goes unreferred, to first one physician, then another, perhaps to a dentist, and utilizes the increasing number of increasingly potent non-prescription medications. The separation of prescribing and dispensing responsibilities provides essential checks and balances that result in better therapy and guard against inadvertent prescriber errors, which can be life-threatening to the patient.

A recent court decision recognized the pharmacist's essential and complementary role in this system of checks and balances. The court, in the case of *Riff v. Morgan*, noted that, "if the consensus of the medical community is that a safety net of over-lapping responsibilities is necessary to serve the best interests of patients, it is not for the judiciary

to dismantle the safety net and leave the patients at the peril of one man's (the physician's) human frailty." As pharmacists, we believe that it is our responsibility to ensure that this safety net is maintained for the good of patients and that medical practitioners dispensing be extremely limited.

**T**he legal requirements and professional standards for record keeping, labeling, and dispensing which pharmacists must adhere to are well-founded in good patient care. Physicians and other prescribers who wish to engage in dispensing drugs must assume full responsibility for all appropriate laws and regulations. It is important to note that each of the volumes of federal, state, and Board of Pharmacy laws and regulations pertaining to the practice of pharmacy was established in direct response to a demonstrated need. Everything from standards for refrigeration and light exposure to child-resistant packaging requirements to detailed inventory and record-keeping of controlled substances was established in response to some problem which had developed and for which public policy dictated a regulatory control. Those laws and regulations were developed to protect the public and to affect certain congressional and legislative objectives, e.g., the limited distribution of controlled substances, and it is the responsibility of pharmacists and dispensing prescribers alike to see that the myriad of laws and regulations is fully complied with.

**A**s pharmacists, we are also extremely concerned about the inherent financial incentive for dispensing physicians to narrow a patient's therapeutic options to those medications carried in the physician's limited stock, which in most cases will be fewer than 50 products. This extremely limited but, according to repackagers, profitable inventory restricts the physician's ability to provide patients in every instance with the most cost-effective and therapeutically effective drug. With a prescription order in

hand, patients have the ability to shop for a price and service that they feel is fair.

**O**ne of the arguments put forth by proponents of prescribers selling drugs is that it will somehow enhance competition. There are approximately 50,000 pharmacies in the United States, some 4,000 in Georgia. They are accessible to every citizen. These pharmacies actively compete for patients by providing a variety of price and service options, including convenient hours, dictated by free market competition. What could be more competitive than a statewide distribution system of thousands of pharmacies actively competing for patients? What could be less competitive than a prescriber in the closed confines of an examination room advising an elderly or ill patient that "when you leave, stop by the front desk and we'll have your medicine ready for you"?

**“The separation of prescribing and dispensing provides essential checks and balances.”**

When medical practitioners dispense, the openly competitive pharmacy market is converted into a closed market in which the patient is controlled by the physician-patient relationship. Physicians are perceived as authority figures, and few patients — particularly the elderly, the less educated, and the less assertive — would reject a physician's offer to dispense medications regardless of the price or any other concerns the patient might have but not feel free to voice. A subtle, yet powerful psychologic force is at work here, one that com-

*Continued on p. 36*



# Counterpoint

pels the typical patient "to do what the doctor orders." That is an important force in the relationship between physician and patient, and it is one which should not be jeopardized for 3 or 4 more dollars' profit.

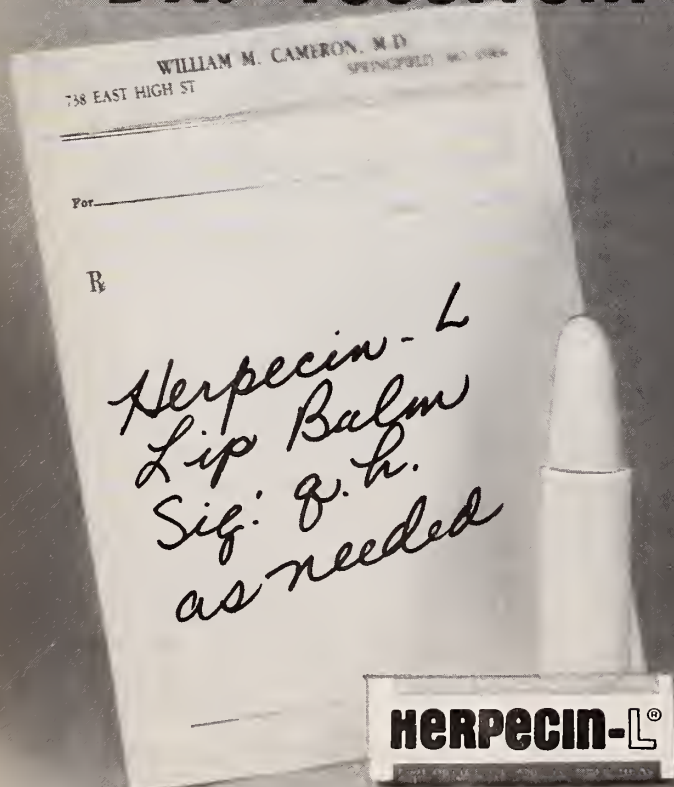
**I**n summary, our Western and American health care distribution system has evolved into a highly specialized, sophisticated, and complex process. Physicians, pharmacists, nurses, and numerous ancillary personnel have vital roles to play in the system. Physicians still, even in the face of increased pressure from governmental agencies,

insurers, and others, play the primary role in determining the care of their patients. A congressional staff person recently made comments which succinctly summarize the feelings of many by saying, in effect, "A physician is a Trustee for the patient. Any Trustee, whether it be for the purposes of executing a will, assuming responsibility for orphaned minor children, or the affairs of any other party, is to be held to the highest level of accountability. It is not sufficient to avoid a conflict of interest; it is mandatory that even the appearance of a conflict of interest be avoided. If we

have established reams of laws to develop standards of responsibility for Trustees in every capacity from universities to corporate boards of directors to executors of estates, shouldn't there be protection from the few who would capitalize on their patients by selling them drugs?"

Pharmacists strongly support the traditional system and the traditional roles of physician and pharmacists working together. We hope that the leadership of medicine will step forward and help us preserve this time-honored process which serves your patients so well. ■

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Before prescribing, see complete prescribing information in SK&F LAB CO. literature or PDR. The following is a brief summary.

**Contraindications:** There are no known contraindications to the use of 'Tagamet'.

**Precautions:** While a weak antiandrogenic effect has been demonstrated in animals, 'Tagamet' has been shown to have no effect on spermatogenesis, sperm count, motility, morphology or in vitro fertilizing capacity in humans.

In a 24-month toxicity study in rats at dose levels approximately 9 to 56 times the recommended human dose, benign Leydig cell tumors were seen. These were common in both the treated and control groups, and the incidence became significantly higher only in the aged rats receiving 'Tagamet'.

Rare instances of cardiac arrhythmias and hypotension have been reported following the rapid administration of 'Tagamet' HCl (brand of cimetidine hydrochloride) injection by intravenous bolus.

Symptomatic response to 'Tagamet' therapy does not preclude the presence of a gastric malignancy. There have been rare reports of transient healing of gastric ulcers despite subsequently documented malignancy.

Reversible confusional states have been reported on occasion, predominantly in severely ill patients.

'Tagamet' has been reported to reduce the hepatic metabolism of warfarin-type anticoagulants, phenytoin, propranolol, chlordiazepoxide, diazepam, lidocaine, theophylline and metronidazole. Clinically significant effects have been reported with the warfarin anticoagulants; therefore, close monitoring of prothrombin time is recommended, and adjustment of the anticoagulant dose may be necessary when 'Tagamet' is administered concomitantly. Interaction with phenytoin, lidocaine and theophylline has also been reported to produce adverse clinical effects.

However, a crossover study in healthy subjects receiving either 'Tagamet' 300 mg. q.i.d. or 800 mg. h.s. concomitantly with a 300 mg. b.i.d. dosage of theophylline (Theo-Dur®, Key Pharmaceuticals, Inc.),

demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg. h.s. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. (Note: All patients receiving theophylline should be monitored appropriately, regardless of concomitant drug therapy.)

Lack of experience to date precludes recommending 'Tagamet' for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks; generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

**Adverse Reactions:** Diarrhea, dizziness, somnolence, headache, rash. Reversible arthralgia, myalgia and exacerbation of joint symptoms in patients with preexisting arthritis have been reported. Reversible confusional states (e.g., mental confusion, agitation, psychosis, depression, anxiety, hallucinations, disorientation), predominantly in severely ill patients, have been reported. Gynecomastia and reversible impotence in patients with pathological hypersecretory disorders receiving 'Tagamet', particularly in high doses, for at least 12 months, have been reported. Reversible alopecia has been reported very rarely. Decreased white blood cell counts in 'Tagamet'-treated patients (approximately 1 per 100,000 patients), including agranulocytosis (approximately 3 per million patients), have been reported, including a few reports of recurrence on rechallenge. Most of these reports were in patients who had serious concomitant illnesses and received drugs and/or treatment known to produce neutropenia. Thrombocytopenia (approximately 3 per million patients) and a few cases of aplastic anemia have also been reported. Increased serum transaminase and creatinine, as well as rare cases of fever, interstitial nephritis, urinary retention, pancreatitis and allergic reactions, including hypersensitivity vasculitis, have been reported. Reversible adverse hepatic effects, cholestatic or mixed cholestatic-hepatocellular in nature, have been reported rarely. Because of the predominance of cholestatic features, severe parenchymal injury is considered highly unlikely.

A single case of biopsy-proven periportal hepatic fibrosis in a patient receiving 'Tagamet' has been reported.

**How Supplied:** Tablets: 200 mg. tablets in bottles of 100; 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only); 400 mg. tablets in bottles of 60 and Single Unit Packages of 100 (intended for institutional use only); and 800 mg. Tiltab® tablets in bottles of 30 and Single Unit Packages of 100 (intended for institutional use only).

**Liquid:** 300 mg./5 ml., in 8 fl. oz. (237 ml.) amber glass bottles and in single-dose units (300 mg./5 ml.), in packages of 10 (intended for institutional use only).

**Injection:**

**Vials:** 300 mg./2 ml. in single-dose vials, in packages of 10 and 30, and in 8 ml. multiple-dose vials, in packages of 10 and 25.

**Prefilled Syringes:** 300 mg./2 ml. in single-dose prefilled disposable syringes.

**Plastic Containers:** 300 mg. in 50 ml. of 0.9% Sodium Chloride in single-dose plastic containers, in packages of 4 units. No preservative has been added.

**ADD-Vantage® Vials:** 300 mg./2 ml. in single-dose, ADD-Vantage® Vials, in packages of 25.

Exposure of the premixed product to excessive heat should be avoided. It is recommended the product be stored at controlled room temperature. Brief exposure up to 40°C does not adversely affect the premixed product.

'Tagamet' HCl (brand of cimetidine hydrochloride) injection premixed in single-dose plastic containers is manufactured for SK&F Lab Co. by Travenol Laboratories, Inc., Deerfield, IL 60015.

\* ADD-Vantage® is a trademark of Abbott Laboratories.

BRS-TG-L73B

Date of issuance Apr. 1987

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Fruits, vegetables, and whole-grain cereals such as oatmeal, bran and wheat may help lower the risk of colorectal cancer.

Foods high in fats, salt- or nitrite-cured foods like ham, and



There is evidence that diet and cancer are related. Some foods may promote cancer, while others may protect you from it.

Foods related to lowering the risk of cancer of the larynx and esophagus all have high amounts of carotene, a form of Vitamin A which is in cantaloupes, peaches, broccoli, spinach, all dark green leafy vegetables, sweet potatoes, carrots, pumpkin, winter squash and tomatoes, citrus fruits and brussels sprouts.

fish and types of sausages smoked by traditional methods should be eaten in moderation.

Be moderate in consumption of alcohol also.

A good rule of thumb is cut down on fat and don't be fat.

Weight reduction may lower cancer risk. Our 12-year study of nearly a million Americans uncovered high cancer risks particularly among people 40% or more overweight.

Now, more than ever, we know you can cook up your own defense against cancer. So eat healthy and be healthy.

No one faces cancer alone.



Foods that may help reduce the risk of gastrointestinal and respiratory tract cancer are cabbage, broccoli, brussels sprouts, kohlrabi, cauliflower.



# Rules of the Georgia State Board of Pharmacy

## Chapter 480-28 Practitioner Dispensing of Drugs

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**480-28-.01 Definitions.** For purpose of these Rules and Regulations, the following definitions apply:

(a) *Drugs.* Drugs shall mean drugs as defined in O.C.G.A. Ch. 26-4 and controlled substances as defined in O.C.G.A. Ch. 16-13.

(b) *Practitioner or Dispensing Practitioner.* Practitioner or dispensing practitioner means a person licensed as a dentist, physician, podiatrist, or veterinarian under Chapter 11, 34, 35 or 50, respectively, of Title 43 of the Official Code of Georgia Annotated.

**480-28-.02 General Requirements.** All practitioners who dispense drugs shall comply with all record-keeping, labeling, packaging, and storage requirements imposed upon pharmacists and pharmacies, with regard to such drugs pursuant to O.C.G.A. Ch. 26-4 and Ch. 16-13, and those regulations contained in this Chapter.

**480-28-.03 Notification of Intent to Dispense.** Any practitioner who desires to dispense drugs shall notify, at the time of the renewal of that practitioner's license to practice, that prac-

itioner's respective examining board of that practitioner's intention to dispense drugs. That examining board shall notify the Georgia State Board of Pharmacy regarding each practitioner concerning whom that board has received a notification of intention to dispense drugs. The examining board's notification shall include the following information:

- (a) The name and address of the practitioner;
- (b) The state professional license number of the practitioner;
- (c) The practitioner's Drug Enforcement Administration license number; and
- (d) The name and address of the office or facility from which drugs shall be dispensed and the address where all records pertaining to such drugs shall be maintained.

**480-28-.04 Record-keeping and Filing.**

(1) *Requirements of a prescription.* A practitioner shall write a prescription for each drug dispensed. The prescription shall contain the following information:

- (a) The full name and address of the person for whom the drug is prescribed;



- (b) The name, quantity, and strength of such drug;
- (c) The directions for taking;
- (d) The signature of the practitioner and the date the prescription was written; and
- (e) For controlled substance drugs, the name, address, and Drug Enforcement Administration number of the dispensing practitioner.

(2) *Documentation required for filling or refilling a prescription.* A practitioner who fills or refills a prescription shall write on the prescription itself the date it was filled or refilled and the signature of the practitioner who fills and refills the prescription.

(3) *Prescription copies.* Only a practitioner, or an assistant acting under the immediate and personal supervision of a practitioner, may prepare a copy of a prescription or read a prescription to any person, and then only to persons authorized to receive such information. When such prescription copy is given, the person giving such copy shall record immediately upon the prescription:

- (a) That a copy has been given;
- (b) To whom given; and
- (c) The date given.

(4) *Retention of records.* Prescriptions shall be kept on file by a practitioner for a period of two years from the date the prescription is filled and shall be accessible for inspection by the Georgia Drugs and Narcotics Agency and its inspectors.

(5) *Special requirements for record-keeping and filing of controlled substance prescriptions.*

(a) *Invoices.* A record of all controlled substance drugs received and disposed of by a dispensing practitioner must be kept. All invoices of Schedule II controlled substances must be kept or maintained in a separate file. All invoices of Schedule III, IV or V controlled substances must be kept or maintained in a separate file, provided that these invoices must be filed with other invoices only if the letter "C" in red ink is stamped on each invoice of Schedule III, IV, or V controlled substances so that such invoices can be easily accessible and retrievable.

(b) *Inventory.* An inventory of all controlled substances must be kept separately and taken biennially on May 1st on every odd-numbered year, unless a different date is authorized by the Drug Enforcement Administration or its authorized representative.

(c) *Files.* A prescription for a controlled sub-

stances must be filed in one of the following ways:

1. A practitioner can maintain three separate files; one for all Schedule II controlled substances dispensed, one for all Schedule III, IV, and V controlled substances dispensed, and one for all non-controlled substance drugs dispensed.
2. A practitioner can maintain two files; one for all Schedule II controlled substances dispensed and one for all other drugs dispensed. If this method is utilized, the prescriptions for Schedule III, IV, and V controlled substances must be stamped with the letter "C" in red ink, not less than one inch high, in the lower right-hand corner, so that such records are easily accessible and retrievable.
3. A practitioner can maintain two files; one for all controlled substance drugs dispensed and one for all non-controlled substance drugs dispensed. If this method is utilized, the prescriptions for Schedule III, IV, and V controlled substances must be stamped with the letter "C" in red ink, not less than one inch high, in the lower right-hand corner, so that such records are easily accessible and retrievable.

**480-28-.05 Labeling.** All drugs dispensed by a practitioner must be labeled with the following information:

- (a) Date and identifying serial number;
- (b) Name of patient;
- (c) Name of practitioner prescribing;
- (d) Name, address and telephone number of the dispensing practitioner;
- (e) Name of drug and strength;
- (f) Directions for use to the patient;
- (g) The expiration date of the drug; and
- (h) Any other information required by the Drug Enforcement Administration or the Food and Drug Administration.

**480-28-.06 Packaging.** All drugs dispensed by a practitioner must be dispensed in containers meeting the requirements of the Food and Drug Administration and the Consumer Protection Agency, including the use of child-proof and moisture-proof containers.

**480-28-.07 Storage.**

- (1) All practitioners shall exercise diligent care in protecting controlled substance drugs and records processed from loss or theft. Agents



of the Georgia Drugs and Narcotics Agency shall have the responsibility of offering to practitioners written recommendations concerning the satisfactory storage, keeping, handling, and security of such controlled substances and records. When not in actual use, all controlled substance drugs shall be kept in a place which is secured.

(2) All drugs which bear, or are required to bear, upon the package, the words "Caution, Federal Law Prohibits Dispensing Without Prescription," or words of like import, shall be stored in a secured area by a practitioner possessing such drugs. All drugs shall be kept beyond the normal reach of small children.

(3) There shall be provided within each practitioner's office sufficient shelf, drawer, or cabinet space for the neat and orderly storage of all drugs. In addition, there shall be clear floor space within such office to permit a practitioner and his assistant employed therein to adequately, safely, and accurately fulfill their duties related to prescriptions and drugs.

(4) There shall be provided within each dispensing practitioner's office adequate facilities for the proper storage of drugs which require refrigeration, and such drugs shall be stored therein in such manner as to preserve their therapeutic activity.

(5) No dispensing practitioner shall operate in any manner or dispense any drugs under unclean, unsanitary, overcrowded, or unhealthful conditions, or under any condition which endangers the health, safety, or welfare of the public.

(6) A practitioner shall cause to be removed from stock all outdated and deteriorated drugs, and such shall be done at regular intervals of not more than six months duration, and under no circumstances will any practitioner permit any drug to be dispensed which bears a date of expiration which has been reached, or any drug which is in a deteriorated condition.

**480-28-.08 Practitioner's Assistants.** Nothing in these rules shall prohibit any person from assisting any duly licensed practitioner in the measuring of quantities of medication and the typing of labels therefor, but excluding the dispensing, compounding, or mixing of drugs, provided that such practitioner shall be physically present and actually observing the actions of such person in doing such measuring and typing, and provided, further, that no prescription shall be given to the person requesting the same unless the contents and

the label thereof shall have been verified by a licensed practitioner. No practitioner shall be assisted by more than one such person at any one time.

**480-28-.09 Practitioner in Charge of Common Inventory.** Whenever more than one practitioner dispenses drugs from a common inventory, one of the practitioners shall be designated "practitioner in charge" of said inventory. All practitioners in charge shall insure that a complete and accurate record of all controlled substances on hand, received, manufactured, sold, dispensed, or otherwise disposed of has been kept in accordance with the record-keeping requirements of federal law, state law, and the rules of the board.

**480-28-.10 Loss or Theft of Controlled Substances.** A loss or theft of any controlled substance drugs must, upon discovery, be reported to the Drug Enforcement Administration and the Georgia Drugs and Narcotics Agency. A written report must be made regarding any theft or loss of controlled substances by completing DEA Form 106. The original and one copy of the report must be sent to the Drug Enforcement Administration and one copy must be sent to the Georgia Drugs and Narcotics Agency. The report shall include the following information:

- (a) Full name and address of practitioner;
- (b) DEA registration number;
- (c) Date of theft;
- (d) Type of theft;
- (e) List of cost codes, or identification symbols on package stolen; and
- (f) List of controlled substances missing.

**480-28-.11 Inspection of Records.** The Georgia Drugs and Narcotics Agency and its inspectors shall have the authority to conduct inspections or audits of all records of drugs received and/or disposed of by any practitioner. Drug inspectors shall have the authority to examine and copy all such records, and to examine and inventory all controlled substances. It shall be the responsibility of all practitioners possessing such drugs or records to make the same available for such inspection, copying, examination, or inventorying by said drug inspectors. Any practitioner possessing controlled substances or records may request that such an inspection be made, and upon receipt of such written request, the chief drug inspector shall make, or cause to be made, without unreasonable delay, an inspection and compliance with said request.





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### SPECIAL FEATURE

Willingway: A Fellowship in Alcoholism and Drug Addiction



# **Medical Association of Georgia's 1987 Report on Human Immunodeficiency Virus AIDS Related Complex and Acquired Immunodeficiency Syndrome**

## **Introduction**

**J**UST 6 YEARS AGO, the United States and Georgia identified their first cases of what was to become Acquired Immunodeficiency Syndrome, commonly known as AIDS. This disease is caused by infection from a virus referred to as the Human Immunodeficiency Virus (HIV). The degree of spread of this disease in just 6 years is epidemic. From the first cases in 1981, there are now over 41,000 AIDS cases, and this number is expected to rise to 323,000 by 1991. The U.S. Public Health Service projects that as many as 200,000 of those infected may be dead by 1991.

The AIDS virus has now been isolated from human blood, semen, bone marrow, tears, saliva, urine, cerebrospinal fluid, lymph nodes, feces, and brain tissue. The virus has also been found in some insects such as mosquitoes, ticks, and lice; however, there are no known cases of insect-borne transmission. The greatest rate of transmission has occurred through sexual contact between homosexual and bisexual men (66%). The next largest category involves intravenous drug abusers (17%), and an additional 8% has been through homosexual male IV drug users; thus 91% of all patients have become infected through one of these methods.

The Centers for Disease Control has recently issued a revised and expanded definition of AIDS to be more consistent with current diagnostic practice (See Appendix 1 for C.D.C. Definition). This new definition should lead to a 15% to 20% increase in the classification of persons having AIDS. Expanded statistics are also being maintained on those persons who develop ARC or AIDS Related Complex. The conversion rate of HIV seropositive persons to AIDS or ARC or related illness in some studies appears to be 70% to 80% rather than the original 20% projection. Current estimates suggest that up to 2,000,000 Americans may be infected with HIV and that by 1991 AIDS is expected to be the second leading cause of premature deaths among American men.

In recognition of this significant health care problem, the Medical Association of Georgia established an ongoing special panel of experts to study and make recommendations concerning what Georgia's physicians consider to be the most important communicable disease hazard in our State. The panel consists of representatives in the specialties of surgery, family medicine, pediatrics, pathology, psychiatry, internal medicine, dermatology, as well as representatives from the

Centers for Disease Control, the Georgia Hospital Association, the Department of Human Resources, the Auxiliary to the Medical Association of Georgia, the Mercer University School of Medicine, the Medical College of Georgia, the Morehouse School of Medicine, and the Georgia Task Force on AIDS. Special thanks and appreciation are extended to the American Medical Association, the Georgia Hospital Association, the American College of Physicians, the Infectious Disease Society of America, and the Surgeon General's Report on Acquired Immune Deficiency Syndrome. Each group has significantly contributed to the recommendations expressed herein. This report reflects an intentional effort by health care providers to coordinate their policies where possible and gratefully acknowledges use of various materials contributed by each group.

**S**ince AIDS is a relatively new and deadly disease, extensive research is being conducted on a world-wide basis. New information becomes available almost daily. The policies and recommendations that follow should be considered in light of this constantly changing information. These policies and recommendations must remain flexible and amendable. A policy that is



viable today may be outmoded tomorrow by new scientific discoveries, new state and federal laws and regulations, and the constantly changing legal developments. Therefore, nothing contained in this report should be regarded as legal advice or in any manner regulating or controlling the practice of any MAG member physician. Likewise, no statement in this report should be interpreted as a recommendation or establishment of statewide standards, guidelines, or policies for any hospital, physician, or other health care provider.

**The purpose of this report is to provide relevant guidance and suggestions to physicians, health care providers, state government, the General Assembly, and the public as each attempts to comprehend and effectively respond to this growing health crisis.**

## **Recommendation 1. Fight Fear With Facts.**

**T**his simple phrase used by the American Red Cross concisely expresses the need to provide rational, scientifically based, and accurate information to both health care professionals and the public. There is a great need for AIDS education. Physicians should assume a major role in educating their patients and the public. The Medical Association of Georgia is committed to active participation on a major scale in the education of health care providers and the public. Printed materials, slide shows, and video presentations, along with personal physician participation are currently being developed and made available. In addition, the Auxiliary to MAG is responding to the need for public education by taking a Red Cross-designed training session and providing speakers and AIDS educational materials to schools, churches, and civic groups in their local areas.

## **Recommendation 2. Education and counseling are significant tools in preventing the spread of HIV.**

**M**ass education and individual counseling as to how the AIDS virus is transmitted are necessary to slow the spiraling transmission of the disease. Known activities that spread the virus, such as high risk sexual behavior and sharing of intravenous needles, are generally consensual and voluntary acts. Teaching the public and individual patients about these unsafe health hazards should help in slowing the spread of AIDS.

## **Recommendation 3. Physicians should consider incorporating into their practice standard procedures for taking complete sexual and drug use histories of their patients and should have candid communication with, and participate in the education of persons known to be at risk for HIV.**

**R**esearch indicates that Americans are often poorly informed about health issues and frequently act on information that is incomplete or misinterpreted. AIDS is an example of this health care information gap that can be narrowed through better communication between physician and patient. Because of the complex nature of the disease and the constant emergence of new information, physicians should make special efforts to remain currently informed about the latest information even if they do not have any patients with AIDS or ARC.

Though there is a general reluctance to discuss sexual preference and practices or illegal intravenous drug abuse, physicians are encouraged to take the sexual and drug use history of their patients, especially of new patients. If a physician feels that a patient may be in one of the high risk groups, then the physician's responsibility is to be frank and explicit with those patients in educating and discussing

the consequences of their behavior. The infectious nature of the disease, the methods of transmission, and the steps that can be taken to lessen exposure to the virus should be discussed candidly with such patients.

## **Recommendation 4. Physicians, nurses, and other health care providers are urged to provide competent and humane care to all patients, including patients infected with HIV, or who have developed ARC or AIDS.**

**P**hysicians are under an oath and ethical obligation to treat persons in need of medical care. At the same time, the American Medical Association and the Medical Association of Georgia recognize the inherent right of a physician to accept or reject a particular patient. The AMA's Council on Ethical and Judicial Affairs states:

*"Physicians are free to choose whom they will serve. They physician should, however, respond to the best of his ability in case of an emergency where first aid treatment is essential. Once having undertaken a case, the physician should not neglect the patient, nor withdraw from the case without giving notice to the patient, the relative, or responsible friend sufficiently long in advance of withdrawal to permit another medical attendant to be secured."*

The decision to withdraw or refuse to treat a patient should not be made solely on the basis that the patient has HIV seropositive or has AIDS or ARC. The likelihood of the physician or health care worker contracting the virus through medical care contact is extremely remote if properly applied safety guidelines are followed (see Appendix 2 for CDC suggested safety precautions). Physicians should also be aware that the bylaws of a hospital could be modified or pres-



ently may already require a staff physician to treat all patients. This could include AIDS patients, Medicaid patients, indigent patients, etc. Before a physician refuses to treat an AIDS patient in a hospital, the hospital bylaws should be reviewed.

**Physicians have a long and honored tradition of tending compassionately and courageously to patients afflicted with infectious diseases and that tradition must and will be continued throughout the AIDS epidemic.**

**Recommendation 5. Counseling and testing for the AIDS virus should be readily available to all who wish to be tested.**

The local, state and federal governments should insure that both counseling and testing are available for all individuals, including those who cannot afford to pay for it. The availability of testing alone is insufficient to meet the needs of individuals at risk. Testing must be accompanied with competent counseling.

**Recommendation 6. Mandatory testing of the general population or even all hospital or emergency room admissions is not necessary at this time, however there is an appropriate role of some limited mandatory testing.** (Discussed in detail in other recommendations.)

The knowledge that a person is infected with the AIDS virus can be the crucial predicate to alter a patient's behavior. Thus, testing for an antibody to the AIDS virus, when used in conjunction with appropriate counseling, serves the important public health purpose of providing impetus for behavior changes that could minimize the risk of transmitting the AIDS virus.

Clearly, the need for HIV testing has expanded beyond its original use, the screening of blood donors. Guidelines for the appropriate use

of HIV testing must center on the following justifications:

1. To identify infected persons, to offer treatment where possible, and to protect uninfected third parties.
2. To offer education and counseling that could modify high risk behavior.
3. To solicit patient cooperation for locating and referring sex partners.
4. To obtain broadened epidemiological statistics on the prevalence of HIV infection in the population.

In addition, when considering the merits of voluntary versus mandatory testing, these facts about AIDS should be kept in mind:

1. AIDS is caused by an infectious agent and therefore is an infectious disease. Appropriate precautions, procedures, and policies should be applied to protect the community from the spread of the disease.
2. The extent to which the AIDS virus already has spread into the general population is not completely known. Current projections are based on a number of unverified assumptions.
3. The transmission of the AIDS virus has not been shown to occur through casual person-to-person contacts such as hand shaking, using the telephone, etc. Sexual contact, septic intravenous equipment, and the administration of infected blood and blood products are the main modes of transmission.
4. Heterosexual transmission of the AIDS virus does occur. Transmission can occur from female to male (as shown by high incidence in Africa). Current U.S. data shows a higher incidence of male to female transmission.
5. HIV seropositive pregnant women will transmit the virus to their babies in a high percentage of cases.

6. Health care workers, especially those who perform invasive surgical procedures, emergency room and laboratory personnel, or any workers who are exposed to blood or other body fluids are at some risk when caring for HIV seropositive, ARC, or AIDS patients.
7. No patient with a clinical case of AIDS has survived the disease. The disease has been uniformly fatal.
8. The disease, not its victims, is the threat from which society must be protected.
9. The confidentiality of the doctor/patient relationship is vitally important but not absolute.
10. Physicians have an ethical and professional obligation to behave in a scientifically responsible manner.

Because the risk to health care personnel will be slight in most areas, any effort at mandatory testing of certain patients should be instituted after voluntary testing has failed and where a variety of factors, e.g., the cost and availability of proper testing and counseling as measured against the risk presented by the relative presence of a high risk patient population, weigh in favor of mandatory testing.

**When considering AIDS legislation, the General Assembly should review and give consideration to a comprehensive revision and consolidation of various health care statutes such as those involving communicable diseases, infectious diseases, tuberculosis, preventable disease, etc.** For information purposes, a summary of a comprehensive 1986 Texas statute is attached as Appendix 3.

One section of the Texas statute established a procedure for employer-required HIV testing of certain employees. Under this statute the employer has the right to test an employee if the test is necessary as a "bona fide occupational qualification" which is reasonably related to the satisfactory perform-



ance of the duties of the employee. This might include an employee whose occupation requires intimate contact with patients or blood handling. The Texas statute also provides that testing for HIV may be required in order to manage accidental exposure to blood or other body fluids.

**Recommendation 7. Testing for the AIDS virus should be mandatory for donors of blood and blood fractions, organs and other tissues intended for transplantation in the U.S. or abroad, for donors of semen or ova collected for artificial insemination or in-vitro fertilization, for immigrants to the United States and for military personnel.**

**M**ilitary personnel have traditionally been subject to mandatory immunizations and our defense forces, of course, must be as strong as possible. Immigrants should be tested as the nation certainly has the right to bar entrants with communicable diseases. The need to test donors of blood, organs and semen has never been questioned.

**Recommendation 8. Testing for the AIDS virus of local, county and state prison inmates should be mandatory if the sexual and drug use history of the inmate indicates any high risk behavior; likewise, the test should be available for any inmate requesting the test. Additionally, jails and prison systems should meet their obligation to protect the general (unexposed) prison population by segregating HIV seropositive patients.**

**P**rison inmates, because they are confined and are exposed to a higher number of high-risk individuals than the general population, require special protection. Data on HIV seropositive inmates is limited at this time, therefore MAG feels that the decision to order mandatory testing of all inmates should be re-

served until more complete information is obtained. The State of Maryland conducted a study on a limited sample of inmates which indicated that 7% of their prisoners were HIV seropositive.

Since Georgia has an inmate population of 18,000, application of the Maryland study to Georgia statistics would indicate approximately 1300 HIV seropositive inmates in Georgia. This estimation may be inaccurate because of the small sample used in the Maryland study and because Georgia has a higher incidence of AIDS cases.

**The Department of Corrections is urged to immediately make the test available upon requests to all inmates.** Presently the test is given to an inmate only if he is already sick and showing "medically indicated" ARC or AIDS symptoms or upon a "documented exposure incidence." Even with this limited testing, DOC has identified approximately 125 inmates as being HIV seropositive. Presently 70 inmates are HIV seropositive, 4 more have AIDS and an additional 16 have ARC. As of November 1, 1987 13 Georgia prison inmates have died from either ARC or AIDS.

**The Department of Corrections should also immediately implement mandatory testing of all homosexuals, all bisexuals, all sex offenders and all drug offenders. Inmate intake procedures should be modified to require administrative review of all inmate records to determine if the inmate is in any of the high risk categories.** For example, the present intake process asks if the inmate has ever "used drugs" but fails to ask if intravenous use has occurred. Also, the rate of inmates admitting to using drugs appears to be lower than actual users. Attention should be given to the development of a plan including HIV testing and family counseling to follow parolees and other released inmates who are homosexual, bisexual, sex offenders, drug offenders or have any history to indicate high risk behavior.

Presently all HIV seropositive inmates are separately housed at the Augusta Correctional Medical Institution. Regardless of the size of the HIV seropositive inmate population, MAG feels that the Department of Correction has a duty to protect the uninfected population from exposure to the virus. **Because of the nature of the population (high incidence of violence, deviant behavior, drug abuse, etc.) and because of the high incidence of coerced homosexual acts (estimated as high as 60%), it is recommended that HIV seropositive inmates be segregated.**

**Recommendation 9. Counseling and testing should be strongly encouraged and offered for the following individuals in the following settings:**

1. Patients at sexually transmitted disease clinics.
2. Patients at drug abuse clinics.
3. Pregnant women at high risk.
4. Individuals seeking family planning services who are at high risk or who engage in high-risk practices.
5. Patients requiring surgical or other invasive procedures who are at high risk or who engage in high-risk practices. If the voluntary policy is not sufficiently accepted or if a treatment facility is located in an area with a high incidence of AIDS, the treatment facility and medical staff should consider a mandatory program for the facility. This should be on a case-by-case basis and should not apply to all treatment facilities.

MAG urges physicians to routinely counsel and encourage *anyone* to be tested for the antibody to the AIDS virus who is homosexual or bisexual, has a history of intravenous drug use, or is a spouse or sexual partner of a homosexual, bisexual, prostitute or any other person who, given his or her personal history, the physician be-



lieves may be at some risk. **MAG does not feel that it is appropriate for mandatory testing of all marriage license applicants.** Current studies are inadequate to draw such a conclusion. **Therefore, MAG recommends that DHR initiate a pilot test program to obtain the necessary data from which a proper policy can be developed. MAG also recommends development of a program to distribute AIDS educational materials to all marriage applicants that would explain who is at high risk and encourage those at high risk to obtain HIV counseling and testing.**

**Recommendation 10. Absent a specific patient directive, a physician should exercise medical judgment when ordering an HIV test.**

Physicians should encourage voluntary HIV testing for individuals whose history or clinical status warrant such action based on medical judgment. Physicians, however, are not bound by statute to specifically disclose each and every test or procedure after a patient has placed himself under a physician's care. MAG feels that it is therefore the responsibility of a physician to exercise medical judgment when ordering an HIV test.

Georgia's Medical Consent Act requires disclosure of the *general course* of the proposed treatment or procedure. It does not require disclosure of the "risks of treatment" nor each and every test or procedure to be applied to a particular patient. Consent for HIV testing is an issue over which legal experts will disagree because there has not as yet been a case in Georgia litigated on this issue. There are two important points for a physician to consider. First, some contend that because of the fear of lawsuits surrounding AIDS patients that a physician consider getting either a general written release or an HIV specific release. Second, a patient in Georgia has the right to refuse

"treatment," therefore if a patient specifically instructs his physician not to conduct an HIV test, then it should not be performed. Likewise, if the patient refuses to follow or cooperate with the medical judgment of the physician, then the physician is within proper bounds to terminate the physician/patient relationship.

Because of the fear of litigation physicians more and more are securing the patient's written consent to treatment and testing although such consent is not required by statute. Some utilize a general release, while others have elected to secure the patient's signature on a special consent form which specifically addresses the HIV antibody test. This voluntary form might describe to the patient something about the test, the possibilities of false positives, and that the testing procedure will involve more than one test if the initial test is positive. Many of these voluntary forms also explain to the patient what may happen to the results of the tests. For example, the form could include discussion about the release of the test results to other physicians and health care practitioners responsible for the patient's care and treatment. In addition, the form could acknowledge, as with any other document reflecting medical information, that it could be subject to release by subpoena or other legal process as may be required by Georgia law. The patient's acknowledgment of the fact that the results will become part of the patient's medical record could prove helpful in defending a later claim by the patient that release of AIDS-related information enclosed in the record was unauthorized or illegal. Special attention should be given to requests for insurance information if the medical record contains any HIV testing information. (See Appendix IV for examples of both general and HIV specific release forms.) (For a more complete discussion of various legal issues see Appendix V which is an article that appeared in

the January, 1987, issue of the *Journal of the Medical Association of Georgia*.)

**Recommendation 11. Physicians should assist patients with AIDS in coping with the reality of the generally fatal nature of the disease.**

One of the problems of AIDS is the debilitation and death of young persons who have not yet thought about dealing with health care emergencies or death. Health care providers must also prepare themselves to face the terminally ill patient who, rather than being in his seventies or eighties is in his twenties, thirties or forties. Below are some provisions of the law which should be brought to the health care provider's attention in order to aid with these problems.

Georgia law provides for the designation of a person to be appointed as one's **guardian** should one become mentally or physically incapacitated. This can be helpful when the patient's family is experiencing difficulty in coping with the patient's lifestyle and where the patient would prefer a non-family member to make medical decisions for him/her. See O.C.G.A. 29-5-2(c) (1).

**Living wills** may also be important to those with AIDS. Institutional health care providers should be careful not to exceed the legal limitations as to the distribution of sample living will forms, but perhaps mentioning such to friends or family members of the patient would be appropriate. Physicians may distribute living will forms in their private practices. Living Will forms can be obtained free of charge by contacting MAG.

Georgia is a state that allows what is commonly referred to as a "durable" **power of attorney**. That simply means that the powers given by an adult to another adult to act on his/her behalf endure or continue even if the consenting adult becomes incapacitated. A power of



attorney generally is limited to business affairs, but some legal authorities feel that a power of attorney could also include health care decisions. This specific issue has not been litigated in Georgia and should be made effective only when the person is incapacitated. **MAG urges the General Assembly to resolve this uncertainty by amending O.G.C.A. 10-6-5 to specifically include health care decisions.**

**Recommendation 12. HIV test results, ARC, and AIDS information should be treated as confidential medical information the same as any other medical information.**

All health care providers have a legal and ethical obligation to respect the privacy and confidentiality rights of all patients, regardless of their ailment. Under Section 24-9-40 of the Official Code of Georgia Annotated, hospitals and physicians are prohibited from releasing any medical information concerning a patient without the patient's written authorization, a valid subpoena, or a court order. Any proposed release of AIDS-related information must therefore be governed by this and other Georgia legal requirements. Privacy and confidentiality are particularly important to the AIDS patient because disclosing the fact that a patient has AIDS can have serious consequences on various factors in the patient's life. However, since AIDS is also a communicable disease, there are certain instances where release of information is determined by statute, regulation, case law or ethical considerations when such disclosure is in the interest of protecting the public health.

There is constant conflict between the patient's right of privacy and the public's right to be protected from unnecessary spread of any communicable disease. Physicians must therefore be extremely careful in handling any patient-

identifiable HIV information. The competing interests mentioned above must be balanced on a case-by-case basis. Physicians should be aware that there are both tort and criminal actions that can be brought in certain circumstances for the improper release of medical information. The tort actions most likely would center around "privacy" violations. The criminal sanctions range from a possible \$50,000 fine for violation of the Federal statute governing release of records of alcohol and drug abusers to state misdemeanor violations involving the release of information in child abuse and rape cases. (See O.C.G.A. 19-7-5, 49-5-44 and 16-6-23). When a medical record contains HIV information special attention should be given to any "Notice for Production of Documents." These are commonly used by the adverse party in a lawsuit to obtain the medical records of a physician's patient. Consult with the patient and the *patient's* attorney before releasing such information. Close cooperation and consultation are also advisable between the physician and his/her own legal counsel.

**Recommendation 13. Physicians and certain other health care providers should be given the statutory authority to notify third parties who may be at risk of infection from a patient of the physician.**

Physicians are presently caught in a legal crossfire between the patient's right of confidentiality and the physician's duty to protect the public or specific third parties from the spread of this fatal communicable disease. **The General Assembly needs to pass specific statutory authority for physicians to disclose to foreseeable third parties who are potentially at risk of contracting the virus.** Given the life or death consequences, the unsuspecting third party should be warned because there is no cure and because it may not be responsible to rely solely on the infected

person to provide suitable warning.

If the patient refuses to cooperate and release the physician to disclose to third parties, then alternatives (absent statutory change) should be considered by the physician. The only present approach is to notify county boards of health or appropriate public health personnel. They can then inform the third parties under the communicable disease statutes.

As a practical matter, health care providers will have to choose between the potential for suit for invasion of privacy and the potential for suit for failure to protect the health of others. Georgia courts have recognized liability on the part of one sexual partner who failed to inform the other that he/she had herpes. *Long v. Adams*, 175 Ga. App. 538 (1985). Persons who are found to be HIV positive should be aware of this potential for liability. It is possible that in some instances statutory and/or case law may also develop to require notification of one's own sexual partners of any sexually transmitted contagiousness.

It should be noted that release of information concerning HIV positive patients should be dealt with carefully. Unless legislation, regulations or court decisions authorizing release in other instances are put into effect, such information should not be released without a release, subpoena or court order unless the protection of the physical health of others is at stake.

Specific statutes must be drafted by the General Assembly which, while protecting to the greatest extent possible the confidentiality of patient information, (a) provide a method of warning unsuspecting sexual partners, (b) protect physicians from liability for failure to warn the unsuspecting third party, (c) establish clear standards for when a physician should inform the public health authorities, and (d) provide clear guidelines for public health authorities who need to trace the unsuspecting sexual partners of the infected person.



**Recommendation 14. Individuals who are found to be HIV seropositive should be reported to appropriate public health officials on a confidential basis with enough information to be epidemiologically significant.**

**A**IDS is reportable in Georgia and has been a reportable disease in most states since 1983. The Georgia Department of Human Resources is empowered to declare certain diseases and injuries to be "diseases requiring notice" and to require the reporting of such diseases to the county board of health and to the Department of Human Resources. Such data "as are deemed necessary and appropriate for the prevention of certain diseases and accidents as are determined by the department" may be required to be reported. DHR's Office of Epidemiology regularly issues an updated list of all "notifiable" diseases, 42 in all, which includes hepatitis, mumps, rabies, syphilis, gonorrhea, and tetanus. AIDS was added to the list on January 4, 1984. All such reports and data are deemed confidential and are not open to inspection by the public. Those submitting good faith reports or data to DHR in compliance with this statute are protected from liability from civil damages. O.C.G.A. section 31-12-2.

Although an identified AIDS case is presently reportable, the fact that a person is HIV seropositive is not mandatorily reportable. From 1981 through November 1987 there have been 1,006 AIDS cases reported in Georgia. Official DHR estimates indicate that the number of HIV seropositive persons (the potential carriers of AIDS) is somewhere between 30,000 and 60,000 persons. **MAG urges DHR to exercise its authority to expand the scope of reportability to include persons who are HIV seropositive.** If DHR fails to do so, then the General Assembly should mandate HIV seropositive reporting. The only exception to this reporting requirement should be that test results ob-

tained at the 10 DHR HIV testing sites would remain anonymous. However, counseling at those sites should encourage HIV seropositive persons to immediately seek medical attention and advice for their own benefit and for the protection of society. The justification for HIV seropositivity reporting include assisting in tracking the extent of infection, further identification of individuals at risk, and allowing for contact tracing when indicated. The prevention of infection by other sexually transmitted diseases may be important in lessening the probability of an HIV seropositive person from developing AIDS or ARC and adds further impetus to requiring the reporting of HIV seropositivity. Recent reports of greater response to the drug AZT by patients whose treatment began early also supports HIV seropositive reporting.

**Recommendation 15. Civil and criminal sanctions should be imposed against those who are HIV seropositive and who fail to act responsibly to prevent the spread of the virus.**

**G**iven the risk of infection being transmitted sexually, and given the dire potential consequence of transmission, serious consideration should be given to sanctions, at least in circumstances where an unsuspecting sexual partner subsequently finds out about a partner's infection and brings a complaint to the attention of authorities.

**MAG urges the Board of the Department of Human Resources to revise its rules involving sexual offender testing to include a more comprehensive listing of "high risk" offenders.** (See Appendix 6 for a more complete position.) Civil tort actions, along with specific criminal statutes should also be enacted by the General Assembly.

**Recommendation 16. Physicians should enter HIV test results into the patient's medical record.**

**W**hile recognizing the need for confidentiality, a physician's duty is both to his patient and to recognize the main purpose of a medical record. The medical record, though the property of the physician and for his/her primary use, is also to provide a complete and accurate history of relevant medical facts. The record is a document to which the patient has an absolute right to obtain. The patient may want the record because he wishes to change physicians, or the physician may no longer be available to treat the patient.

There is no statutory requirement that a positive or even negative HIV test result be or not be entered into the medical record. However, there is a potential for liability if someone is harmed by the failure to enter the test result into the record. Physicians are urged to enter HIV information into the medical record the same as any other relevant medical information.

**Recommendation 17. The General Assembly should revise the present O.C.G.A. 31-14, "Hospitalization for Tuberculosis" and O.C.G.A. 31-12, "Control of Hazardous Conditions, Preventable Diseases, and Metabolic Disorders" to comply with current due process procedural requirements.**

**B**oth the statute dealing with Tuberculosis and the statute covering Preventable Diseases provide for the involuntary isolation or segregation of infected persons. Both statutes predate many of the state and federal court decisions concerning due process rights when one's liberty is restricted. As the AIDS virus continues to spread and when some infected persons act irresponsibly, then these alternatives to criminal incarceration need to be available to protect society.

There is also a method of involuntary commitment through the mental health statutes (O.C.G.A., Title 37). It is felt that mental health commitment should be reserved for



those HIV seropositives, ARC or AIDS patients who are exhibiting specific mental health manifestations or are otherwise committable for other reasons.

**Recommendation 18. The Department of Human Resources is encouraged to increase its program of contact tracing. The General Assembly is urged to provide adequate funding.**

**T**he Department of Human Resources has already instituted a limited program of contact tracing of those persons who have been exposed to the disease by a HIV seropositive person. This program needs to be expanded and preparations need to be made for the increased number of infected persons to be contacted. The General Assembly must recognize the importance of this DHR public health function and provide adequate funding for staff and support services. One reason the virus is spreading so rapidly is that many "carriers" are unaware of their infection. Once they learn of this infected state, their prior sexual partners need to be contacted and tested.

**Recommendation 19. The Department of Human Resources should develop a comprehensive plan to deal with the long-term health care needs and related costs of AIDS and ARC patients.**

**W**hen AIDS was first identified in 1981, the life expectancy of a victim was from 6 to 9 months. The present expectancy is up to an average of 18 months and should continue to increase with the advent of new treatment drugs such as AZT. Newly identified AIDS patients this year will generate an estimated \$2.25 billion in hospital costs alone. Indirect costs and outpatient services are additional expenses.

Alternatives to extensive and costly hospitalizations need to be identified and established. Nursing

home beds need to be made available and hospice programs modified to meet the specific needs to AIDS patients. The lack of available community based options for AIDS patients in most cities contributes to prolonged and more costly hospital admissions.

Regardless of the treatment alternative to acute hospital care (i.e., nursing homes, home health care, hospice, etc.), greater utilization of ambulatory services should result in earlier and less intensive medical intervention and treatment better suited to a patient's immediate needs. Appropriate use and support of these services will also result in a reduction in the overall cost of care for both provider and patient.

Comprehensive planning and development of alternatives to extensive hospitalizations must be evaluated and implemented in the near future. The General Assembly will again play a major role by providing adequate funding.

**Recommendation 20. Children who are HIV seropositive or have ARC or AIDS should be allowed to attend school. Additionally, sex education including AIDS information should be included in the school's curricula.**

**N**one of the identified cases of AIDs in the United States are known or are suspected to have been transmitted from one child to another in school, day care or foster care settings. Transmissions would require exposure of open cuts to the blood or other body fluids of the infected child, a highly unlikely occurrence. Routine safety procedures for handling blood or other body fluids, which should be standard for all children in the school or day care setting, should be effective in preventing transmission to children in schools from those who are HIV seropositive, have ARC or AIDS. Special consideration is warranted for those children who are HIV seropositive and who lack control over body secretions, prone to biting,

spitting, or vomiting or have open skin lesions.

Children with AIDS are highly susceptible to infections from other children who have childhood diseases, such as chicken pox. Each child with AIDS should be examined by a doctor before attending school or before returning to school, day care or foster care settings after an illness. No blanket rules can be made for all school boards to cover all possible aspects of children with AIDS. Therefore each case should be considered separately and individualized to the child and the setting, as would be done with any child having a special problem, such as cerebral palsy or asthma. A good team to make such decisions with the school board would be the child's parents, physician and a public health official. **MAG urges school boards to adopt policies that call for decision-making on children with AIDS to be made on a case by case basis which is founded on medical judgment, not on emotionalism or unfounded fears.**

Casual social contact between children and persons infected with the AIDS virus is not dangerous. Schools will have special problems in the future as they attempt to deal with the complexities of AIDS. Education about AIDS should start in early elementary school and at home so that children can grow up knowing what behavior to avoid and how to protect themselves from exposure to the AIDS virus. The threat of AIDS can provide an opportunity for parents to instill in their children moral and ethical standards.

Parents, educators and community leaders — indeed all adults — cannot disregard this responsibility to educate our children. The need is critical and the price of neglect is high. The lives of our young people depend on the appropriate execution of that responsibility.

Adolescents and pre-adolescents are those whose behavior we wish to influence especially because of their vulnerability while exploring their own sexuality, and perhaps experimenting with drugs. Teen-



agers often consider themselves immortal, and uninformed young people may be putting themselves at great risk.

Education concerning AIDS should be part of a health and hygiene program. Educational professionals in conjunction with health care professionals should develop the appropriate curriculum on AIDS education. Care should be given in selecting the grade level in which to insert AIDS education. Special care should be given to the qualifications of persons teaching information on AIDS. Only teachers with special instructions on AIDS should be permitted to lead such classes. There is no doubt now that we need sex education in schools and that it must include information on sexual relationships. The threat of AIDS should be sufficient to permit a sex education curriculum with a heavy emphasis on prevention of AIDS and other sexually transmitted diseases.

#### **Closing**

**T**he Medical Association of Georgia intends to continually review its evaluation of the developing AIDS epidemic. Information and treatment are changing daily. Modifications of these recommendations will be made as the situation warrants. This report was formally adopted by MAG's Board of Directors on September 19, 1987, with final changes made and adopted by the MAG's Ad Hoc Committee on AIDS on November 2, 1987.

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# Myths or Facts?

- Even moderate social drinkers may risk liver damage.
- Women are more likely to suffer liver damage from alcohol than men.
- Most victims of liver disease are *not* alcoholics.

All three statements are *true*.

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## Some Comparisons Between MAG and DHR's Policy Statements on AIDS

Richard Greene

**“The DHR Task Force on AIDS and some social groups have endorsed AIDS-specific strict confidentiality legislation. This is probably the most significant point of demarcation between MAG's position and that of the DHR Task Force.”**

Mr. Greene is MAG's General Counsel. Direct inquiries to him at 938 Peachtree St., Atlanta, GA 30309.

**I**N THIS ISSUE of the *Journal*, you will find a copy of MAG's policy statement on AIDS (p. 41) which was adopted by the Board of Directors. It was developed by the Task Force appointed and chaired by MAG President Jack F. Menendez, M.D. The Georgia Department of Human Resources (DHR) also established an AIDS Task Force chaired by one of MAG's members, W. Douglas Skelton, M.D. Regrettably, the length of the DHR Task Force's Report precludes its inclusion in the *Journal*. This article, however, will highlight some of the similarities and differences between the two reports. (A copy of DHR's Report may be obtained from Mr. Dave Humphreys at DHR in Atlanta.)

**M**AG and the DHR Task Force agreed on more points than they differed. The DHR Task Force is to be complimented for its call for: (1) more education of the public about AIDS; (2) supporting criminal sanction against HIV seropositive individuals who knowingly expose others; (3) supporting a provision to permit, but not require, physicians to notify spouses or known sexual partners of an HIV

seropositive patient and also provide immunity from liability to the notifying physician; (4) supporting legislation that makes it clear that health care providers can disclose HIV information to other necessary health care workers; (5) supporting the concept of counseling of HIV patients; and (6) opposing unnecessary mandatory HIV tests.

The DHR Task Force on AIDS and some social groups have endorsed *AIDS-specific strict confidentiality legislation*. This is probably the most significant point of demarcation between MAG's position and that of the DHR Task Force. The Task Force also differs in that it supports anti-discrimination statutes involving employment and insurance, revising the handicapped code to include AIDS patients, and it opposes adding HIV seropositivity to the list of sexually transmitted diseases. MAG obviously does not endorse discrimination of AIDS patients, nor do we endorse new legislation that would create numerous lawsuits and additional expense to the employers in the state. MAG feels that HIV seropositivity should be reported



to DHR and that DHR should conduct more contact tracing. MAG also calls upon the Georgia General Assembly to provide adequate funding to expand contact tracing, thereby helping to slow the spread of this dreaded disease.

**T**here is constant conflict between the patient's right of privacy and the public's right to be protected from the unnecessary spread of a communicable disease. Physicians must, therefore, be extremely careful in handling any patient-identifiable HIV or other communicable disease information. The competing interests mentioned above must be balanced on a case-by-case basis. Physicians should be aware that there are both tort and criminal actions that can be brought in certain circumstances for the improper release of medical information. The tort actions most likely would center around "privacy" violations. The criminal sanctions range up to a possible \$50,000 fine for violations involving the release of information in child abuse and rape cases. (O.C.G.A. 19-7-5, 49-5-

44 and 16-6-23). When a medical record contains HIV information, special attention should be given to any "Notice for Production of Documentation." These are commonly used by the adverse party in a lawsuit to obtain the medical records of a physician's patient. Consult with the patient and the *patient's* attorney before releasing such information. Close cooperation and consultation are also advisable between the physician and his/her own legal counsel.

MAG is opposed to AIDS-specific confidentiality legislation. MAG feels that HIV, ARC, and AIDS information should be treated the same as any other medical information. While recognizing that AIDS-related information is sensitive and should be handled with care, the law currently provides a cause of action against a person who wrongfully releases *any* confidential medical information. Such for an additional statute which would create new staff problems and confusion.

It is MAG's position that there is no need for such legislation because all health care providers presently have a legal and ethical obligation to respect the privacy

and confidentiality rights of all patients, regardless of their illness. Under Section 29-9-40 of the *Official Code of Georgia Annotated*, hospitals and physicians are prohibited from releasing any medical information concerning a patient without the patient's written authorization, a valid subpoena, a court order, or as required by statute to DHR. Any proposed release of AIDS-related information must therefore be governed by these and other Georgia legal requirements. Privacy and confidentiality are particularly important to the AIDS patients, because disclosing the fact that a patient has AIDS can have serious consequences on various aspects of the patient's life. However, since AIDS is also a communicable disease, there are certain instances where release of information is permitted by statute, regulation, case law, or ethical consideration, generally when such disclosure is in the interest of protecting the public health.

You are urged to contact your legislators and educate them about the problems surrounding AIDS-specific confidentiality statutes while you educate them about AIDS in general. ■



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**Carcinogenesis, Mutagenesis, Impairment of Fertility:** No evidence of drug-related tumorigenicity was found in chronic oral toxicity studies of 24 months' duration conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies have not been conducted.

**Pregnancy:** Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

**Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

**Pediatric Use:** Safety and effectiveness in children have not been established.

#### ADVERSE REACTIONS

Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients, adverse effects were reported in 121 (4.7%). Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

#### DOSAGE AND ADMINISTRATION

The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

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# Georgia Department of Human Resources' Five-Year Plan on AIDS

Robin Yaeger Swift, M.P.H.

**T**HE 1987 GEORGIA GENERAL ASSEMBLY passed House Resolution 166, directing the state's Department of Human Resources (DHR) to prepare a 5-year plan detailing the impact of the Acquired Immune Deficiency Syndrome (AIDS) on Georgia's human and fiscal resources. With the cooperation and assistance of many public and private agencies, physicians, hospitals and individuals, the plan is complete and has been forwarded to the General Assembly.

The document highlights issues and recommendations in the following key public policy areas: prevention, antibody testing and counseling, service delivery, legislation, and costs. Special AIDS issues in the care of pediatric patients, persons with hemophilia, intravenous drug users, mental health clients, and incarcerated populations, and in the management of persons with AIDS (PWAs) who require adult guardianship, are also explored in the plan. Recommendations were derived from agency, community, and provider surveys in both the public and private sectors, from other states' experiences, and from the current literature. Statements, projections, and other data represent the best consensus about AIDS planning in 1987. Readers of the plan are cautioned that this epidemic is a dynamic one, and that both its data and its recommendations may be subject to change based on new information.

**T**his article summarizes the plan's major recommendations and the background data which supports them. Georgia's current AIDS epidemiology forms the basis for the Department's long-range planning: some 5000 new cases of AIDS will be reported in Georgia between 1988-1991. A change in the surveillance definition for AIDS will result in a striking increase among pediatric cases: between 80-100 children are expected to be diagnosed with AIDS within the next 4 years. Cases in Georgia will continue to predominate among homosexual/bisexual males and intravenous (IV) drug users; however, the number of heterosexual contact and perinatal transmission cases is projected to increase. If national trends are borne out, cases will also shift from urban centers to rural areas.

AIDS surveillance is an ongoing activity of the Department of Human Resources. It is accomplished through enhancing the case-finding activities of physicians and hospitals, supporting improved reporting mechanisms, and conducting seroprevalence studies. The Atlanta Standard Metropolitan Statistical Area is one of 30 cities participating in the new federal seroprevalence study being conducted by the Centers for Disease Control (CDC). The purpose of the study is to define the prevalence of HIV infection in selected populations in order to assess whether AIDS will be confined to its original risk groups or has spread into the population at large. In addition to this study, DHR also monitors seroprevalence among methadone center clients, sexually trans-

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mitted diseases patients, and selected other populations, including a sample of premarital syphilis serologies.

**T**he Five Year Plan's key epidemiology and surveillance recommendations include the following:

- \* Anonymous or voluntary, confidential seroprevalence studies should continue under the supervision of DHR;
- \* DHR should maintain data systems tracking all AIDS activities, in order to inform future planning and programming;
- \* Any data system containing information about persons with AIDS, ARC, HIV infection, or risk behaviors should be maintained with maximum precautions to protect confidentiality. No data with personal identifiers should be released without express written patient consent, except under specific statutory requirements or court order.

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***Mandatory HIV antibody testing is discouraged as an epidemic control strategy due to problems with test accuracy in low risk populations and with discrimination against those found to be antibody positive.***

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Voluntary antibody testing, accompanied by counseling, has proven a useful tool for assisting persons at risk for HIV infection to assess their antibody status and motivate personal behavior change. Such testing has been available in the state's major health districts since 1985. In the past year, testing sites have been expanded, and all 159 county health departments now offer antibody testing and counseling. The state laboratory has performed over 24,000 antibody tests during 1987 alone.

Mandatory HIV antibody testing is discouraged as an epidemic control strategy due to problems with test accuracy in low risk populations and with discrimination against those found to be antibody positive. Along with the issues raised by mandatory versus voluntary testing comes the issue of the cost of the increasing demand for testing. Based on the current wide availability and acceptability of voluntary, anonymous anti-

body testing programs, the plan makes the following recommendations about antibody testing:

- \* Voluntary, anonymous HIV antibody screening should continue to be offered to persons seeking to know their antibody status;
- \* Voluntary HIV antibody screening should be offered in clinics where individuals at risk of infection may seek care: family planning and obstetric clinics, sexually transmitted diseases clinics; drug treatment clinics;
- \* Consistent policies and statutes protecting confidentiality of HIV antibody test results and medical records should be developed and enforced;
- \* AIDS education materials should be given to every marriage license applicant.
- \* Follow-up counseling and support programs for persons who test antibody positive should be made available.

The vast majority of projected cases for 1991 are *already infected* with the AIDS-causing Human Immunodeficiency Virus (HIV). In the absence of a vaccine, improved medical therapy, or a cure, there is nothing that can be done in the intervening 5 years to prevent these cases from occurring. Prevention education about AIDS must reach *every* Georgian if new infections and cases are to be prevented. The primary strategy of the Department of Human Resources in the prevention of AIDS is through education. To that end, the plan recommends the following:

- \* Resources to expand DHR's AIDS education/risk reduction activities should be increased. Target groups for these efforts should include: the general public, groups at increased risk of infection, children and adolescents, health-care workers, and those who are already infected;
- \* Preservice and inservice education programs for educators and human service professionals should be implemented;
- \* All state employees should be educated about AIDS;
- \* A coordinated statewide network of AIDS education should be created in cooperation with the many public and private agencies involved in AIDS education;
- \* The effectiveness of AIDS education programs should be monitored and evaluated.

At the close of November, 1987, Georgia had reported over 1000 cases of AIDS. Physicians estimate that there are 5-10 times as many cases



of AIDS-related complex (ARC) as there are cases of AIDS. Based on federal forecasts, as many as 40,000-60,000 Georgians may already be infected with HIV. People along the entire spectrum of HIV infection, from asymptomatic, antibody positive to full-blown AIDS, have needs for medical and social services: for diagnosis, treatment, emotional support, behavior modification assistance, practical support, advocacy, and referral. In 1987, there is no coordinated, statewide system of care that is meeting those needs in Georgia.

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***The Plan forecasts the morbidity and mortality expected from AIDS through 1991 and proposes some solutions to the dilemmas that AIDS will pose for the health service delivery system.***

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The Department of Human Resources has been questioned about its assertion that this disease will demand a comprehensive, coordinated response. AIDS presents a unique combination of factors that influence public policy. First, it is a contagious disease, of epidemic proportions, caused by a heretofore unknown retrovirus: these factors alone demand a public health response. Second, the original risk groups for infection in the United States were already vulnerable to social prejudice and isolation: this epidemic has heightened discrimination and fear. Third, AIDS is a disease that predicts medical indigency for many who will be ill and die from it. Persons with AIDS are usually young, with little financial equity to meet the expenses of a catastrophic illness. Many of the infected who are working and insured against such medical care costs will become disabled by their illness, losing both their jobs and their insurance. Others will lose employment or insurance due to discrimination. Still others, particularly IV substance abusers, are medically indigent to begin with. When personal and family resources are exhausted, and when health insurance is unavailable or used up, these people will become dependent on the public sector for their care.

Unless state agencies act now, in concert with each other, with state and federal funding sources, and with private and public health providers, the costs of indigent AIDS care may overwhelm the public sector health delivery system. To anticipate the growing service demands on that system and to establish a continuum of care services to meet the needs of HIV positive, ARC, and AIDS patients, the Department has proposed the following:

- \* To fund five regional Ambulatory AIDS Treatment Centers and combine them with Grady Memorial Hospital's ambulatory clinic to create a statewide system of ambulatory care for the spectrum of HIV-related disease in the medically indigent;
- \* To develop a regional pediatric AIDS care system in conjunction with the Ambulatory AIDS Treatment Centers, with separate funding;
- \* As a cost control measure, to develop a regional AIDS case management system in conjunction with the regional centers. Case managers would act as the referral centers for inpatient, nursing home, hospice, and social service care. Reimbursement mechanisms and contracts for all aspects of such care would be developed jointly by the Departments of Human Resources and Medical Assistance;
- \* A strong network of inpatient hospital care must be developed for persons with ARC and AIDS. Current and new medical/psychiatric beds must be identified for patients displaying symptoms of severe neurologic HIV infection. Both public and private providers must be involved in the establishment of an inpatient care network;
- \* A variety of additional or new service alternatives should be developed, including nursing home and inpatient hospice care, medical daycare, alternative housing services, and other support services;
- \* New resources for drug treatment and community mental health care must be identified to cope with the increasing demands presented by AIDS;
- \* State agencies should work with the Georgia insurance industry to identify options for financing AIDS-related care and insurance;
- \* Community organizations should be encouraged to take an active role in the provision of support services to people with AIDS and ARC;
- \* DHR supports public policies that prohibit discrimination against persons with HIV infection, ARC, or AIDS.



State government will play a role in facilitating the development and delivery of AIDS-related care. Government will also be involved in quality assurance monitoring, in the training of staff professionals, in data analysis, and in planning.

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***The Atlanta Standard  
Metropolitan Statistical Area is one  
of 30 cities participating in the new  
federal seroprevalence study being  
conducted at the Centers for  
Disease Control.***

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Within its special issues chapter, the plan proposes additional recommendations for special populations:

- \* Increased medical care and social service support facilities for pediatric AIDS patients;
- \* Increased planning and resources for both private and public mental health care for HIV-infected and symptomatic clients;
- \* Examination of new legal procedures for incapacitated persons with AIDS which will be less comprehensive than adult guardianship;

- \* Expansion of AIDS education outreach to, and drug treatment services for, IV drug users and their sexual partners;
- \* Expansion of services and support to persons with hemophilia;
- \* Expansion of AIDS prevention and treatment capabilities within the Georgia correctional system, including education of staff and inmates, expansion of antibody testing capability, and increased medical care capability for inmates with symptomatic HIV infection.

The Georgia AIDS Five Year Plan is a beginning document for future long-range planning to manage the impact of the AIDS epidemic. The Plan forecasts the morbidity and mortality expected from AIDS through 1991 and proposes some solutions to the dilemmas that AIDS will pose for the health service delivery system. Successful implementation of recommendations will depend on an ongoing, cooperative dialogue among government agencies, service providers, and those both at risk of and infected with HIV. The document is intended to serve as a point of departure for that dialogue. For further information about the contents of the AIDS Five Year Plan, contact: Dr. James W. Alley, Director, Division of Public Health, Georgia Department of Human Resources, 878 Peachtree St., Atlanta, GA 30309. ■

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# The Efficacy of Measuring Bone Mineral Density in Asymptomatic Women: A Preliminary Report

L. L. Wilkes, M.D., S. D. Barnhill, M.D.

**O**STEOPOROSIS ENJOYS a certain favored status among diseases. The media constantly warns women of the tragic consequences of osteoporosis, and as a result, women have begun to view the disease with a growing fear.

Since 1984, there has also been a dramatic change in the way physicians view osteoporosis. With the development and popularization of highly sensitive techniques for measuring bone density, such as Dual Photon Absorptometry (DPA) and Quantitative Computed Tomography (QCT), physicians are now capable of measuring the density of the proximal femur and the lumbar vertebrae. The National Institutes of Health (NIH) 1984 Consensus Conference stimulated those interested in bone density with its recommendations for "defining persons at risk, and developing safe, effective, and low cost strategies for fracture protection."<sup>1</sup>

With the technology already in place, the NIH report was a green light to interested parties to begin to set up screening centers for osteoporosis. It is estimated that there are now 300 such centers in operation, and approximately 30 to 40 new centers are being opened each month in the United States.<sup>2</sup>

Is screening asymptomatic women worth the time and cost? The

literature is contradictory. Early favorable reports<sup>3</sup> were strengthened by commercialism as proponents of different methods published their results and recommendations.<sup>4, 5</sup> The popularization of the "fracture threshold" has heightened interest among physicians despite the fact that the value of the fracture threshold has not been tested.<sup>6</sup> Recently, some researchers have denounced osteoporosis screening as an ineffective use of the health care dollar,<sup>7, 8</sup> while others have offered rebuttals to such denouncements.<sup>9</sup>

Amidst such uncertainty, we set out to evaluate the usefulnesses of our bone density testing program. We concluded that, while wide scale screening of asymptomatic women for osteoporosis may not be useful or practical, a combined program of education and bone density testing in perimenopausal women with high risk factors can be recommended.

## Methods and Materials

**B**one mineral content (density) was determined in 122 Caucasian women between the ages of 40 and 60 years who answered yes to three or more of the following risk factors:

- Do you have a strong family history of osteoporosis?

- Are you petite or small in size?
- Are you fair or blonde?
- Do you live a sedentary lifestyle?
- Have you undergone menopause (natural or surgically)?
- Do you smoke one or more packs of cigarettes per day?
- Do you drink 6 or more oz. of alcohol per day?
- Are you on dilantin or thyroid medication?

Bone mineral content was measured using the technique of radiographic absorptometry (RA). Space does not permit a full discussion of this technique which has been described in the literature.<sup>3</sup> Likewise, no intention is made to compare RA to DPA or QCT. It should be noted, however, that RA has a higher correlation coefficient with Total Body Calcium (TBC) than either of the other two methods.<sup>10</sup>

Of the 122 women, 31 were found to be positive (more than 1 SD below the mean value for both mid life normals and aged matched normals), and 91 were either negative or borderline (more than 1 SD be-

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low the mean value for mid life normals but less than 1 SD below the mean for age matched normals). Those in the positive group were referred to an appropriate physician for evaluation. In the negative and borderline groups, recommendations were made affecting their diets, lifestyle, activity level, calcium intake, and in some cases, hormone therapy.

At the end of one year, the 91 negative and borderline women were polled using a written questionnaire to determine the degree of compliance with the recommendations. A total of 67 percent of the women responded to the questionnaire.

### Results

**C**ompliance was determined for each recommendation made, and the results are summarized below.

*Dietary Calcium:* 22% had a calcium intake of 1 gm. or more prior to their visit. Recommendations to maintain or increase dietary calcium or to add calcium supplementation were made in 88%. All of the women were in compliance at the end of a year.

*Exercise:* 15% were exercising at an equivalent of a 3-mile walk three times a week prior to their visit. Recommendations to begin an exercise program or to increase their existing program were suggested in 81%. At the end of one year, 27% of these women were in complete compliance, and an additional 67% were in partial compliance with the suggestions.

*Hormone Replacement:* 22% of the women were on replacement estrogen-progesterone prior to their visit. Recommendations to add hormone replacement were made in another 32% (79% were postmenopausal). In those receiving recommendations for hormone replacement, 100% reported discussing the recommendations with their personal physician, and of those, 87% were begun on replacement therapy.

In summary, the degree of compliance with each of the recommendations were as follows: ade-

quate calcium intake, 100%; adequate or improved exercise, 94%; hormone replacement when indicated, 91%.

We have not made an attempt to determine the exact outcome of those 31 positive individuals referred for further evaluation. However, we have determined that all of them were evaluated, and most are in active treatment programs.

### Discussion

**S**creening for diseases is nothing new, but special problems are encountered in screening asymptomatic women for low bone mass. Osteopenia is a continuum rather than a disease which can be measured as positive or negative. By the time osteopenia progresses to the state of osteoporosis (requiring a stress factor by definition, and with a depletion of 30% of bone mass by agreement), the bone reversibility may be questionable.

Obviously, the efficacy of a detection program in such a disease is more difficult to evaluate than in other diseases which have historically accepted screening methods. Various methods have been used to determine the success or failure of screening programs. Ott and Cummings have argued, at least on theoretical grounds, that screening for osteoporosis cannot be recommended<sup>7,8</sup> Monroe submitted his work to the eight points of screening proposed by Wilson and Junger, and determined that the effort was worthwhile.<sup>3</sup>

**I**t seems obvious that the ultimate measure of effectiveness in any early detection program is the degree to which the individual can be protected from a disease. Therefore, it is not enough to simply identify those in the population with low bone mass. To be effective, the program must cause the individual to make certain alterations to protect themselves from the disease. Based upon this assumption, we chose to determine the success or failure of our program by the end results.

There is certainly no unanimity of opinion as to the prevention and treatment of osteoporosis. Opinions vary, but most would agree that

calcium and exercise in moderation and hormone replacement when not contraindicated have a positive effect on bone mass. Such was the consensus at a recent meeting at the NIH.<sup>11</sup> Having made recommendations based upon this consensus and having demonstrated excellent compliance among the participants, it will now remain to be seen if there is an ultimate influence on the fracture rate in the future.

### Conclusion

**I**t is our conclusion that, while indiscriminate screening of asymptomatic women cannot be justified, selective screening in those individuals at increased risk appears to be effective. If a program is to have real meaning it should contain a strong teaching component with specific recommendations for each individual, and the program should not only be a measurement of bone mass. While our efforts appear to have had a positive effect on the women in this study, the final result will be the effect of such efforts on the fracture rate in the future.

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interested in a **full-time emergency medicine** opportunity at our client hospital in Gainesville. Duties include coverage of 30,000-visit hospital emergency department and rotation through affiliated clinic. Gainesville is located in the foothills of the Blue Ridge Mountains, less than an hour drive from Atlanta. Guaranteed rate of compensation in excess of \$105,000 annually, occurrence malpractice insurance coverage, CME allowance, relocation assistance, reimbursement of professional dues. Requirements include board certification in emergency medicine or board prepared and actively pursuing emergency medicine boards. For complete details, contact Dan Howard, Spectrum Emergency Care, P.O. Box 27353, St. Louis, MO 63141; 1-800-325-3982; 314-878-2280.

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# "High Quadriplegia— The Ultimate Challenge"

Plan to attend:

**A two-day symposium  
at Colony Square  
Atlanta**

**April 7-8, 1988**

**Registration: \$225**

Symposium  
Co-Chairmen

David F. Apple, Jr., M.D.  
Medical Director

Donald P. Leslie, M.D.  
Medical Director  
High Quadriplegia Program

A medical symposium addressing the acute and rehabilitative care of the C-1 through C-4 high quadriplegic. Hosted by Shepherd Spinal Center in Atlanta, now the nation's largest dedicated spinal cord injury hospital. Issues to be investigated include: medical, psychosocial and high tech approaches to care and rehabilitation. Special emphasis on ventilator weaning, the interdisciplinary care approach, phrenic nerve pacer implants and community reintegration.

## **Symposium Preview:**

### ***High Quadriplegics: They Can Go Home Again***

With high quadriplegics surviving at unprecedented rates, quality of life issues and discharge planning are of paramount importance from the first

day of admission to the specialty setting. The philosophy of treatment at SSC will be covered, including the referring physician's role in long-term medical management.

### ***Medical Overview: Care of the High Quadriplegic***

The potential for complications such as deep vein thrombosis, stress ulceration, decubitus, pneumonia, urinary tract infections and sepsis poses a serious threat to high quadriplegic patients. Prevention strategies, the benefits of early mobilization of ventilator dependent patients and medical management of complications are covered.

### ***Ventilator Weaning***

All high quadriplegics at Shepherd Spinal Center are evaluated to determine their candidacy for phrenic nerve pacer implants and their potential for weaning from mechanical ventilation. The pulmonary evaluation studies performed at SSC and protocols for weaning are included.

## ***Panel and Concurrent Session Topics:***

- Pulmonary Issues
- Social Work: Discharge Planning, Peer Support, Sexuality
- The Therapeutic Value of Sensory Experience
- The Biofeedback Program at SSC
- Ventilator Home Care
- Focus On: Phrenic Pacer Implantation
- Departmental Presentations by O.T., P.T., Recreation Therapy, Social Work, Respiratory Care, Education, Nutritionists
- Emphasis on specialized equipment

## ***For Physicians Only:***

Grand Rounds at Shepherd Spinal Center

REGISTRATION IS LIMITED. Reserve your space today, by sending a check for \$225, payable to Shepherd Spinal Center, to: Lesley M. Hudson, Symposium Registrar, Shepherd Spinal Center, 2020 Peachtree Road, N.W., Atlanta, GA 30309. Confirmations of early registrations and a symposium information packet will be mailed in October.

### ***High Quadriplegia— The Ultimate Challenge***

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Specialty \_\_\_\_\_

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complete information  
packet.



## **Case Study: Larry McAfee**

### **Diagnosis: C-1 Complete**

### **Prognosis: Promising**

Contact the Admissions Office for routine information. A physician is on 24-hour call to assist in emergency arrangements.

When 28 year-old Larry McAfee was brought to Shepherd Spinal Center as a result of a motorcycle accident in late 1985, he was classified as a C-1 complete spinal cord injury. He was suffering from severe burns on his right ankle, massive atelectasis, pneumothorax and pneumonia. Paralyzed instantly at the first cervical vertebrae below the brain stem, he required mechanical ventilation for breathing.



The road to a meaningful quality of life has been a long one for Larry, requiring intensive medical care, rehabilitation, counseling—and Larry's own unsinkable spirit.

We couldn't promise Larry miracles, but we could promise him the care of the largest rehabilitation hospital in the nation specializing in paralyzing spinal cord disorders, Shepherd Spinal Center in Atlanta. With the help of various adaptive devices and skilled attendants, it is possible for Larry to live independently

in an apartment since his discharge from Shepherd. He now actively pursues his goal of a career as a computer programming consultant.

At Shepherd Spinal Center, our ultimate challenge is to assist patients like Larry in a comprehensive High Quadriplegia Program, (C 1-4). We involve referring physicians in all aspects of discharge planning for follow-up medical supervision with the hope that patients like Larry will go home again.

Your patients count on you. Accept the challenge and work with us...for them.

*The Georgia Regional Spinal Cord Injury Center/Fully Accredited by CARF and JCAH/Designated "Model Spinal Cord Injury Program" by U.S. Dept. of Ed./Now offering a comprehensive Spina Bifida Program/Nation's Largest Dedicated Spinal Cord Injury and Disease Treatment Facility.*

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Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. *N Engl J Med* 1976;294:687-90.

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# MR UPDATE

## MRI is Rapidly Replacing CT & Myelography For Evaluation of HNP

### LUMBAR SPINE

**HISTORY:** This 38-year-old male complained of recent onset of low back pain radiating to left lower extremity.

**SCAN:** This midline sagittal image demonstrates the high intensity (white) discs lying between the vertebral bodies. The L4-5 disc is herniated posteriorly with a "mushroom configuration" (long arrow). CSF in the spinal canal is gray (short arrow), and this CSF column is indented by the herniated disc material at the L4-5 level (long arrow). Axial images at the other levels demonstrated that the high intensity disc material is contained, and disc herniation can be confidently excluded at all the other levels.



**MRI HIGHLIGHTS:** Lumbar and cervical coil MRI is rapidly replacing myelography and computerized tomography for initial evaluation of suspected disc herniation and suspected spinal stenosis. Standard MR examination shows the entire lumbar or cervical spine, the spinal canal and the paraspinal region. Causes of low back or neck pain and sciatica are well demonstrated without injection of contrast material and without ionizing radiation. The bony structures are well shown, and destructive bony lesions and extraosseous extension of bony lesions are routinely demonstrated on MRI. Intraspinous neoplasms are also confidently detectable.



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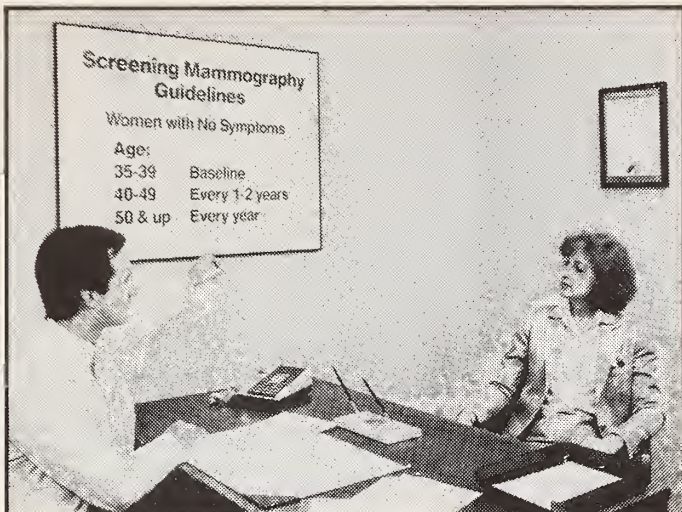
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**COVER**  
Featured on this month's cover is the Cluskey Building of the Medical College of Georgia, in Augusta.





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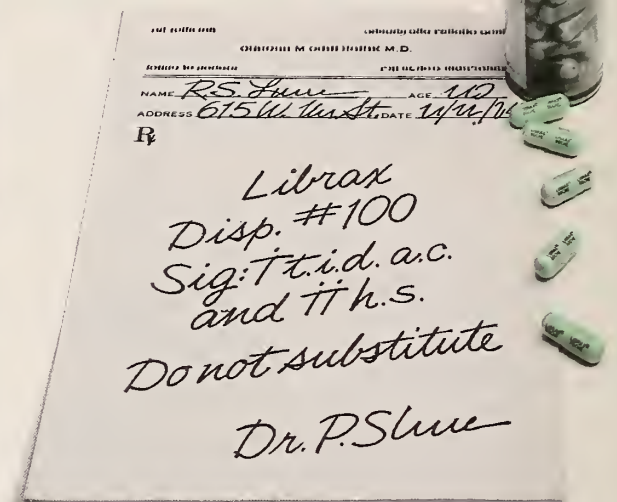


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Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide

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**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

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As with all anticholinergics, inhibition of lactation may occur. **Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



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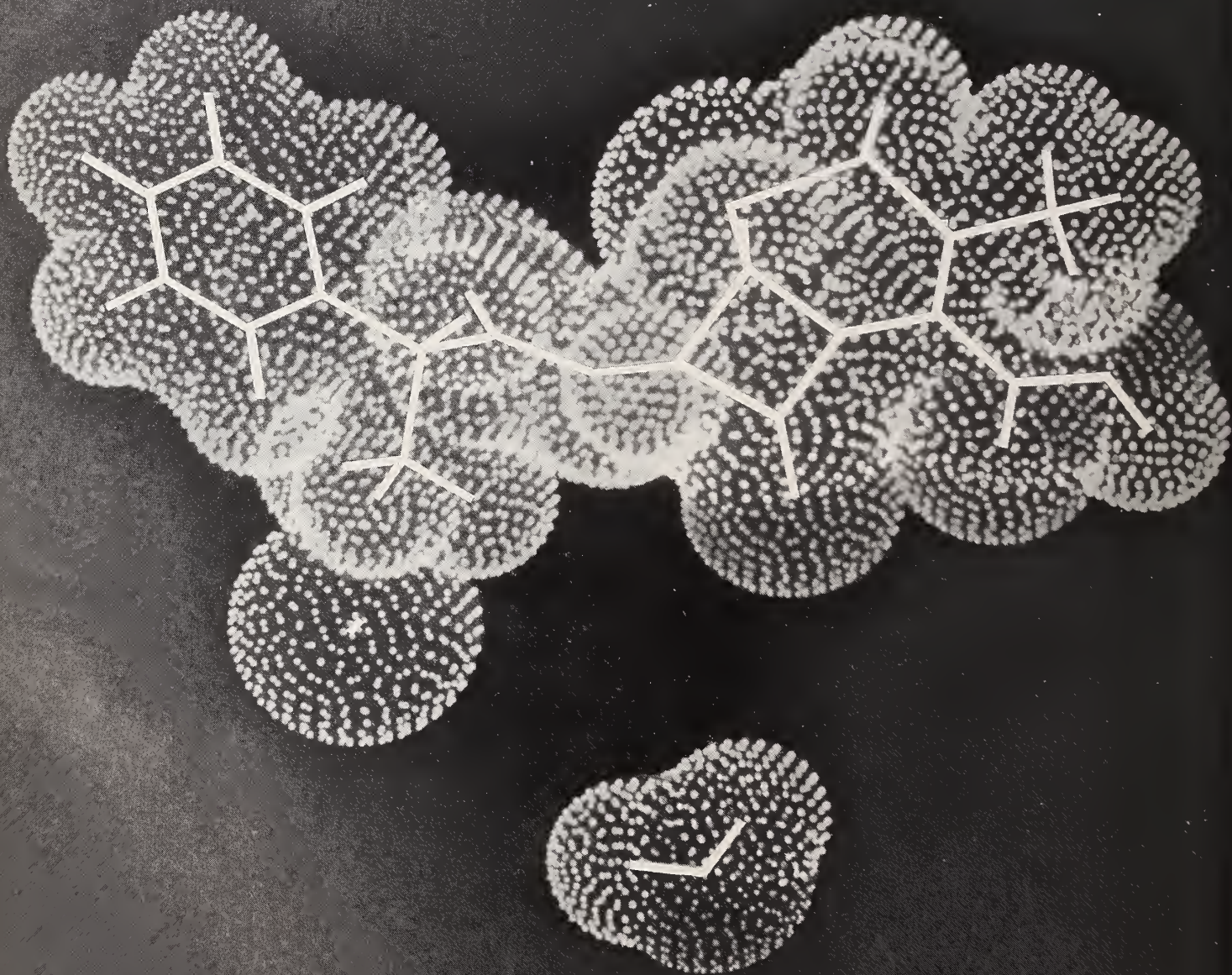


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# Convenient 500-mg b.i.d. dosage and demonstrated effectiveness for treatment of:

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• New hydrochloride salt form of cephalixin—  
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\*Due to susceptible strains of *Staphylococcus aureus* and/or  $\beta$ -hemolytic streptococci.  
†Due to susceptible strains of *Escherichia coli*, *Proteus mirabilis*, and *Klebsiella* sp.  
‡Due to susceptible strains of group A  $\beta$ -hemolytic streptococci.

## KEFTAB™

(cephalexin hydrochloride monohydrate)

**Summary:** Consult the package literature for  
prescribing information.

### Indications and Usage:

*Respiratory tract infections* caused by susceptible  
strains of *Streptococcus pneumoniae* and group A  
 $\beta$ -hemolytic streptococci.

*Skin and skin structure infections* caused by sus-  
ceptible strains of *Staphylococcus aureus* and/or  
 $\beta$ -hemolytic streptococci.

*Bone infections* caused by susceptible strains of  
*S aureus* and/or *Proteus mirabilis*.

*Genitourinary tract infections*, including acute pros-  
tatitis, caused by susceptible strains of *Escherichia*  
*coli*, *P mirabilis*, and *Klebsiella* sp.

**Contraindication:** Known allergy to cephalosporins.

**Warnings:** KEFTAB SHOULD BE ADMINISTERED  
CAUTIOUSLY TO PENICILLIN-SENSITIVE PA-  
TIENTS. PENICILLINS AND CEPHALOSPORINS  
SHOW PARTIAL CROSS-ALLERGENICITY. POSSI-  
BLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with  
virtually all broad-spectrum antibiotics. It must be  
considered in differential diagnosis of antibiotic-  
associated diarrhea. Colon flora is altered by broad-  
spectrum antibiotic treatment, possibly resulting in  
antibiotic-associated colitis.

### Precautions:

- Discontinue Keftab in the event of allergic reac-  
tions to it.
- Prolonged use may result in overgrowth of nonsus-  
ceptible organisms.
- Positive direct Coombs' tests have been reported  
during treatment with cephalosporins.
- Keftab should be administered cautiously in the  
presence of markedly impaired renal function. Al-  
though dosage adjustments in moderate to severe  
renal impairment are usually not required, careful  
clinical observation and laboratory studies should  
be made.
- Broad-spectrum antibiotics should be prescribed  
with caution in individuals with a history of gas-  
trointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined  
in pregnancy and lactation. Cephalixin is excreted  
in mother's milk. Exercise caution in prescribing  
Keftab for these patients.
- Safety and effectiveness in children have not been  
established.

### Adverse Reactions:

- *Gastrointestinal*, including diarrhea and, rarely, nau-  
sea and vomiting. Transient hepatitis and chole-  
static jaundice have been reported rarely.
- *Hypersensitivity* in the form of rash, urticaria, angio-  
edema, and, rarely, erythema multiforme, Stevens-  
Johnson syndrome, or toxic epidermal necrolysis.
- *Anaphylaxis* has been reported.
- *Other reactions* have included genital/anal pruri-  
tus, genital moniliasis, vaginitis/vaginal discharge,  
dizziness, fatigue, headache, eosinophilia, neutro-  
penia, and thrombocytopenia; reversible interstitial  
nephritis has been reported rarely.
- Cephalosporins have been implicated in trigger-  
ing seizures, particularly in patients with renal  
impairment.
- *Abnormalities in laboratory test results* included  
slight elevations in aspartate aminotransferase  
(AST, SGOT) and alanine aminotransferase (ALT,  
SGPT). False-positive reactions for glucose in the  
urine may occur with Benedict's or Fehling's solu-  
tion and Clinitest® tablets but not with Tes-Tape®  
(Glucose Enzymatic Test Strip, USP, Lilly).





5 mg

10 mg

**IS ALWAYS VALIUM<sup>®</sup>**  
brand of  
*diazepam/Roche* <sup>®</sup>

**REMEMBER TO WRITE “DO NOT SUBSTITUTE.”  
IT PROTECTS YOUR DECISION.**



## The Poet In Us All

WE ARE ALL POETS, you know, whether we care to admit it or not. Most of us would rather deny it. It is simpler that way, more defensible. Our retreat into "no one can understand the stuff" takes us away from the necessity of studying and particularly from the need to expend the effort to find the meaning of the words. After all, all artists are a bit touched in the head, aren't they? They certainly appear to live in a different world and one which we dare not enter. But is that not a retreat from effort, a running away from the hard work of looking into the unknown? After all, one can look at any example of modern art and quickly conclude that no intelligent person should spend their time trying to figure out the meaning of blobs of color on a piece of canvas. We were comfortable with Raphael who produced lovely figures and with Van Gogh who understood impressionism and color. Winslow Homer could make one feel a part of the boats and the sea he painted. We understood all of this; it was easy, uncomplicated, and understandable. What was the need to bother oneself with modern foolishness?

That need is the same peculiar, driven, genetically produced characteristic that placed us all in this challenging field of medicine. That peculiar fascination with the unknown, that drive to make clear and understandable that which is

not readily understood. Rudyard Kipling understood this and expressed it simply:

*"Something lost, go and find it  
Go and look beyond the  
mountains.  
Something lost beyond the  
mountains.  
Lost and waiting for you  
Go!"*

That's it. That's why we have to do it, why we cannot avoid doing it for fear of feeling left out, or inadequate, or less than what we might be, or any one of those other demons that drives us to ever seek perfection.

There is poetry in all we do. At least, there should be. The examples are everywhere. How many times, on those early morning rounds, have we heard the response to the query as to how the patient's night went: "It was so long, I thought it would never end"? One needs only to be visited by illness once to experience the loneliness of pain in the dark hours of the night when clock hands move with deathly slowness and abandon, to realize that on occasion it seems that the light and comfort of the day shall never come.

Let me tell you how one poet sees that situation. It appears in one of Emily Dickinson's short poems — she who disappeared into her father's house at age 35,

never to be seen off those grounds for the rest of her life — she who dressed all in white from her 33rd year until her death at 56. Ah, you say, another crazy poet. Perhaps. Yet one with the courage to look into her innermost being and with the talent to describe in rhyme what she saw and felt there. See how she describes the long night of your patient:

*Will there really be a "Morning"?  
Is there such a thing as "Day"?  
Could I see it from the mountains  
If I were as tall as they?*

*Has it feet like Water Lilies?  
Has it feathers like a Bird?  
Is it brought from famous  
countries  
Of which I have never heard?*

*Oh some Scholar! Oh some  
Sailor!*

*Oh some Wise Man from the  
skies!*

*Please to tell a little Pilgrim  
Where the place called  
"Morning" lies!*

—EMILY DICKINSON  
1859

There is a poet in all of us. We hide it, though or try to, much as we hide our pride and ego and oftentimes our sensibility. We are but human, you know, and with all the inherent liabilities to that condition. Why be afraid of poetry, of modern art, indeed, of the unknown itself? It is a part of us all. "Something lost, go and find it!"

Charles R. Underwood, M.D.



# CALENDAR

## MARCH

5 — *Atlanta: Cancer Care in Community Hospitals III: Breast Cancer.* Category 1 credit. Contact Janet Bonfiglio, Am. Cancer Soc., Ga. Div., 46 Fifth St., Atlanta 30308. PH: 404/892-0026.

7-11 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

7-12 — *Augusta: Primary Care and Family Practice Symposium.* AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/828-3967.

10-17 — *Copper Mountain, CO: Snow Job in Gynecology and Obstetrics.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

11-12 — *Atlanta: 25th Annual Ophthalmology Conference.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

11-12 — *Sea Island: Critical Care Conference.* Category 1 credit. Contact Office of CME, Medical Center of Central Ga., 777 Hemlock St., Macon 31208. PH: 912/744-1634.

16-18 — *Hilton Head Island, SC: Clinical Management of Diabetes and Endocrine Disorders.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3998.

18 — *Columbus: Day of Cancer — Breast and Occult Cancers.* Category 1 credit. Contact Janet Bonfiglio, Am. Cancer Soc., Ga. Div., 46 Fifth St., Atlanta 30308. PH: 404/892-0026.

21-26 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

24-26 — *White Sulphur Springs, WV: 10th Annual Pediatric Postgraduate Course.* Sponsored by Scottish Rite Children's Hospital. Category 1 credit. Contact Darlene Baugus, SRCH, 1001 Johnson Ferry Rd., Atlanta 30363. PH: 404/256-5252.

25 — *Macon: Pediatric Emergencies.* Category 1 credit. Contact office of CME, Medical Center of Central Georgia, 777 Hemlock St., Macon 31208. 912/744-1634.

25-26 — *Atlanta: Hoke Kite Symposium on Children's Orthopaedics.* Sponsored by Scottish Rite Children's Hospital. Category 1 credit. Contact Darlene Baugus, SRCH, 1001 Johnson Ferry Rd., Atlanta 30363. PH: 404/256-5252.

27-31 — *Atlanta: American College of Cardiology.* Category 1 credit. Contact ACC, 9111 Old Georgetown Rd., Bethesda, MD 20814. PH: 301/897-5400.

## APRIL

6-8 — *Atlanta: What's New in Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

14-17 — *Atlanta: American College of Preventive Medicine Annual Meeting.* ACPM, 1015 15th St., NW, Suite 403, Washington, D.C. 20005. PH: 202/789-0003.

15 — *Atlanta: Hepatic Surgery.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

15-16 — *Atlanta: Georgia Chapter, American College of Surgeons Spring Meeting.* Contact Ellis B. Keener, M.D., Secy., 434 Academy St., Gainesville 30501. PH: 404/532-6333.

18-22 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

21-22 — *Atlanta: Emory University Annual Renal Research Conference.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

22-24 — *Augusta: The Specter of AIDS — A Practical Conference for Health Professionals.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

23-27 — *Sea Island: Masters in Gynecology and Obstetrics.* AMA Category 1 and ACOG cognate credits. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

28-29 — *Atlanta: Pharmacology for the Anesthesiologist.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

30-May 1 — *Atlanta: The Cardiac Patient.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

## MAY

1-4 — *Sea Island: Georgia Society of Ophthalmology.* Category 1 credit. Contact Ray M. Williams, GSO, 938 Peachtree St., Atlanta 30309. PH: 404/876-7535 or 800/282-0224.





*Jack F. Menendez, M.D.*

## *A Look at Medical History*

**I**N THIS ISSUE, we take a look at the history of medicine in Georgia. It is a subject of which every MAG member can be proud. From Dr. Crawford Long to the State-of-the Art health care of today, Georgia physicians have participated in the advances of medicine. The history of medicine in Georgia, and the advancements we have made, have required many sacrifices. The great men who made these efforts are part of our history. You will read about some of them in this issue.

**A**s for the *future* of medicine, I hope we can achieve the goal set forth by Virchow in 1849 when he wrote, "Should medicine ever fulfill its great ends, it must enter into the larger political and social life of our time; it must indicate the barriers which obstruct the normal completion of the life-cycle and remove them. Should this ever come to pass, medicine, whatever it may than be, will become the common good of all." ■

*Jack F. Menendez*



## NEW MEMBERS

Alvarado, Alan J. — Bibb —  
(Student) 3300 N. Ingle Pl., Apt.  
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Batts, John E., General Practice —  
Colquitt — 806 Georgia Dr.,  
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— Glynn — 1609 Newcastle St.,  
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Surgery — Gwinnett-Forsyth —  
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Zoret, George D., Family Practice  
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## QUOTES

*He that has truth in his heart need  
never fear the want of persuasion  
on his tongue.*

JOHN RUSKIN

*Learn to distinguish the difference  
between errors of knowledge and  
breaches of morality.*

AYN RAND

*The great need for anyone in  
authority is courage.*

ALISTAIR COOKE

*A friend may be often found and  
lost, but an old friend never can be  
found, and nature has provided  
that he cannot easily be lost.*

SAMUEL JOHNSON



## Hospitals' Medicare Payments See Little Increase

**P**RESIDENT REAGAN has signed into law a bill that cuts Medicare by \$2.1 billion.

Under the terms of the bill, hospitals will see only slight increases in their DRG payments — 3% for rural hospitals, 1.5% for hospitals in cities having more than one million people, and 1% for other urban hospitals.

In addition, hospitals will see their capital payments cut by 12% during fiscal year 1988 and by 15% during fiscal year 1989. The cuts in capital payments, claims the hospital industry, will make the DRG payment increases negligible.

## Georgia Legislators Consider Funding For Indigents

**G**EORGIA'S GOVERNOR, Joe Frank Harris, has announced his recommendations for the 1988 fiscal year budget that would raise the total budget from \$5.7 billion to \$5.9 billion. Included in the budget is \$24.3 million for the Department of Medical Assistance. When combined with federal dollars, that amount will become \$67.2 million.

On the issue of indigent care, the state's legislators are expected to expand Medicaid eligibility for the fiscal year 1989 budget (which begins July 1, 1988). In addition, the Georgia Hospital Association is working with Senator Ed Hine (D-Rome) who plans to introduce a constitutional amendment to increase Medicaid coverage. Hine's proposal would allow county revenues to be earmarked for state Medicaid funds, thus enhancing the possibility of obtaining matching federal dollars.

## No Federal Funding For Abortion

**T**HE HEALTH CARE Financing Administration now prohibits the use of federal Medicaid funds for abortions for women who are victims of rape or incest.

The new rules, which took effect January 19, allow payment for abortions only in cases in which continued pregnancy will endanger the mother's life.

## Maternity Bills Take the Lion's Share of Uncompensated Care

**H**OSPITALS' unpaid maternity bills accounted for 27% of the total uncompensated care costs for 1985, says a report from the Alan Guttmacher Institute in New York.

Of American women of reproductive age, 17% have no medical insurance, and 9% have insurance that doesn't cover maternity care.

## Help For Small and Rural Hospitals in Georgia

**T**HE GEORGIA Hospital Association has developed a proposed constitutional amendment to help small and rural hospitals finance their capital needs, and Rep. Bubba McDonald, chairman of the Appropriations Committee, has agreed to be the sponsor.

The amendment would allow the state to sell general obligation bonds and lend the proceeds to hospitals. A lending program using the bonds would give the state greater flexibility in establishing lending criteria and thereby give the smaller hospitals access to loans at lower interest rates. The amendment must pass the General

Assembly and then be voted on next November before legislation can be adopted.

## Most Hospitals Fall Within HCFA's Predicted Death Rates

**T**HE HEALTH CARE Financing Administration (HCFA) released its data on hospitals' Medicare death rates last month, bringing much criticism from the hospital on the validity of the numbers.

While only 2.4% of the nation's hospitals had death rates higher than HCFA's predicted ranges, many hospitals commented that the rates gave no indication of the quality of care a patient receives.

The Georgia Hospital Association pointed out that the data included deaths occurring within a 30-day period after admission. Thus, a patient who is admitted to a hospital for gallbladder surgery and a week after discharge is killed in a car accident appears as a death resulting from the surgery.

Even the American Association of Retired Persons recognizes that the data "had limited uses" for the consumer, but the group encouraged its members to discuss the data with their physicians.

## Uninsured Population Levels Off

**T**HE NUMBER of uninsured Americans may be leveling off, says a study by the Employee Benefit Research Institute in Washington, D.C.

Between 1985-86, the number of persons having no medical insurance rose by only 82,000, a number the Institute terms "miniscule." The Institute notes that 85% of 1986's uninsured population were employed or were dependents of employed persons.



# Georgia Legislative Update



**A**S IN YEARS PAST, the 1988 session of the Georgia General Assembly is a battleground for the competing interests in the health care field. By the time the legislature adjourns in March, over 200 bills affecting the MAG membership will have been considered.

The issues fall into three categories — **Practice Infringement, Governmental Mandates, and Health-Related.** Bills that we are working on will be tracked under those three categories in the **Legislative Bulletin.** By categorizing legislation in this manner, we're hoping to assist both you and legislators to focus on the inter-relationship of the various bills. For instance, optometrists, chiropractors, nurses, and physical therapists are all attempting to broaden their scope of practice through legislation, rather than education — attempting to infringe on your practice. Those proposals, and others like them, should be looked upon as a group, rather than individually. Efforts should be made by all physicians, regardless of specialty, to oppose infringement legislation. Ultimately, infringement by one health group does damage to good medicine and thus affects every physician's practice.

The second category of legislation relates to potential **Govern-**

**mental Mandates** on your practice. The government could tell you how you will communicate with your patients through informed consent legislation; how much you could be paid by Preferred Provider Organization legislation; and it would require you to provide quality of care and cost data to the state through a version of the Health Care Data System legislation. All of these bills could alter your practice and your relationship with your patients in a major way.

Finally, there is the **Health-Related** legislation which impacts on the health of the general public and may or may not directly affect your practice. The proposed seat belt and AIDS bills are examples of this kind of legislation.

**M**AG's greatest strength has always been, and will continue to be, YOU, its members. You are a part of one of the most respected professions in the world, and physicians have earned that same respect from the Georgia General Assembly.

However, you must continue to communicate with the legislature — in person, preferably, but also by telephone and mail. Get to know your legislators and talk with them regularly, not just when they are about to vote on an issue of importance to you and/or MAG.

Involvement in the political process — getting to know your elected officials, working on and contributing to campaigns, being a Doctor of the Day, taking part in the Physician Involvement Program — these activities all require time and effort, which is a lot to ask of you. However, the scope and freedom of your practice is largely determined by elected officials and non-elected regulatory bureaucrats. Some of these officials want to micro-manage the entire field of health care — including your practice. They are in the minority now, but only involvement by you and your fellow physicians in the political and legislative process will insure that they stay a minority. To ignore these processes is to ignore your practice and your patients. **TIME SPENT COMMUNICATING WITH LEGISLATORS SHOULD BE VIEWED AS AN INVESTMENT IN YOUR PRACTICE AND IN THE WELL-BEING OF YOUR PATIENTS.**

The MAG staff wants to work with you to protect your ability to practice medicine and to protect quality to practice medicine and to protect quality health care. We welcome any help and suggestions you have. Please call on us if we can provide you any assistance. ■

*Scott Mall, Director,  
MAG Governmental Relations*



## *Medical History Thrives: The Atlanta Medical History Society*

**"T**he physician must have a thorough knowledge of the history of the world and of the society in which he lives, and he must also know the links between the past and his present duties. For without history, nothing has a full meaning."

FELIX MARTI-IBANEZ

ARIEL, "THE FABRIC AND CREATION OF A DREAM"

**O**N FEBRUARY 14, 1980, Dr. J. Willis Hurst wrote Dr. John Stone and me, asking us to organize a "Medical History Society." From our long experience with Dr. Hurst, we immediately recognized that this was not just a Valentine's card from the chief to two of his beloved faculty, but more like the marching orders to launch a new project that we had been casually discussing with him for several years. After some preliminary planning, an esteemed group of interested people, including Crawford Barnett, Dean James Glenn, Stephen Gray, J. Willis Hurst, John Skandalakis, John Stone, Julius Wenger, and James Harvey Young convened on October 8, 1980, to consider the merits of a new medical history society. (We subsequently learned that an Emory Medical History Club was in existence from 1924-1928.)

At the meeting, Dr. Hurst discussed the importance of medical history and the need for a medical

historical society in Atlanta. Everyone enthusiastically endorsed the idea, and it was agreed that it should be a cooperative effort between the medical school and the Medical Association of Atlanta.

The Atlanta Medical History Society (AMHS) was chosen as the name of our fledgling organization and its purposes were to be:

1. To bring together people who share an interest in the history of medicine for periodic lectures on medical historical subjects.
2. To share material of historical interest.
3. To encourage an interest in medical history in the community and in the medical school.

**D**ean Glenn provided some critical initial funds to defray costs, other medical history societies were soon contacted for suggestions, bylaws were written, and a slate of officers was selected. Our first meeting was held at the Atlanta Historical Society on January 14, 1981, with James Harvey Young, the Candler Professor of American History at Emory (and our only real historian) speaking on "American Health Quackery: A Historical View" with about seventy-five in attendance. We modestly concluded that we had demonstrated sufficient interest and would be able to fill

an important cultural void in the medical community. Since then, the Atlanta Medical History Society has faithfully convened quarterly to hear prestigious visiting speakers such as William Bennett Bean, Robert Zollinger, Martin Cummings, Gert Brieger, Eugene Stead, Mark Ravitch, James Breeden, Bruce Fye, Sharon Romm, Alex Sakula, and Franklin Garrett as well as many of our own members. Topics have included: Walter Reed and the Conquest of Yellow Fever, The Legacy of William Beaumont, Fielding Garrison and His Book, Freud's Struggle With Cancer, The Conquest of Smallpox, Vesalius and Harvey, Eating Habits of Early Hunting-Gathering Man, The First Clinical Cardiac Catheterization: Grady Hospital 1944, Preventive Medical Practices of the Nineteenth Century, The History of Emory Medical School, History of Euthanasia, Electricity and the Heart, Joseph Goldberger and the Conquest of Pellagra, William Osler, Bookbinding, James Herrick, William Cobbitt, The Shroud of Turin, and a Civil War Medical Diary. Our most notable achievement was a day-long symposium, "Medicine at the Time of the Civil War," which was held April 28, 1984 at the Academy of Medicine and co-hosted with The American College of Physicians and The American Osler Society.



The meetings, which are currently held at the Academy of Medicine, have attracted anywhere from 20 to 250 history buffs, including physicians, spouses, medical librarians, history and medical students, medical residents, and others. In addition to talks, we encourage members to bring for demonstration antique medical objects or old books that they have collected.

**“From our long experience with Dr. Hurst, we immediately recognized that this was not just a Valentine’s card from the chief to two of his beloved faculty, but more like the marching orders to launch a new project that we had been casually discussing with him for several years.”**

**I**n 1983, with the support of Frank Wilson, John Yaeger, and the Medical Association of Atlanta executive committee, the AMHS

became part of Atlanta Medical Heritage. This provided a community basis for our structure as well as a fine place to meet. As the AMHS has developed under the leadership of Nick Davies, John Stone, Barry Silverman, and myself, we have continued to try to foster a spirit of respect for our medical heritage in the community and the medical school. The current membership is about 100 with a usual quarterly gathering of 20 to 30 members who enjoy paying homage to our hoary heroes over wine, peanuts, and occasional brie in the comfortable surroundings of the Academy of Medicine library. If you are interested in joining, speaking, or just coming to a meeting, please contact Dan Byrd, M.D. (340 Boulevard, N.E., Atlanta, Georgia 30312). Dues are an affordable \$10 per year. The next meeting will be 7:30 p.m., Thursday, March 31, 1988 and the speaker will be Bruce Fye, M.D., the editor of “Classics of Cardiology” and a recognized authority on cardiac history. He will speak on “The History of Nitrate Therapy.” Please come. Who knows? . . . In the words of Rokitsky, you may “Light your torch on the flame of ancients.”

*Mark E. Silverman, M.D.,  
Past President  
Atlanta Medical History Society*

## **A defense against cancer can be cooked up in your kitchen.**

There is evidence that diet and cancer are related. Follow these modifications in your daily diet to reduce chances of getting cancer:

- 1.** Eat more high-fiber foods such as fruits and vegetables and whole-grain cereals.
- 2.** Include dark green and deep yellow fruits and vegetables rich in vitamins A and C.
- 3.** Include cabbage, broccoli, brussels sprouts, kohlrabi and cauliflower.
- 4.** Be moderate in consumption of salt-cured, smoked, and nitrite-cured foods.
- 5.** Cut down on total fat intake from animal sources and fats and oils.
- 6.** Avoid obesity.
- 7.** Be moderate in consumption of alcoholic beverages.

No one faces cancer alone.

 **AMERICAN CANCER SOCIETY**



## *Restoration Project Offers New Hope to MCG's Cluskey Building*

**T**HE YEAR 1988 will go down in the history of the Medical College of Georgia as a monumental year. After a lengthy discussion with the owners of the old Medical College building and the Foundation Board, the Alumni Association has achieved a leasing arrangement for the old Medical College. After years of waiting, we now have the opportunity to restore one of the classic monuments of medicine in the state of Georgia by means of the Restoration Project now in progress.

Whereas the majority of buildings in the United States circa 1835 were built by journeymen, carpenters, and builders, the Medical College of Georgia building was designed by Charles B. Cluskey, a nationally renowned architect. Mr. Cluskey incorporated his grasp of neo-classical principles to make this building a significant heritage from our past by virtue of its aesthetic beauty and the integrity of its design. The old Medical College building endures as a brilliant example of his ideals, is one of the few surviving examples of the Greek revival architecture in Georgia, and is listed on the National Registry of Historic Places.

But far more than the architectural significance of the building is its significance regarding medical education in the South. It was at the time the third

oldest medical college in the South and the 13th oldest in the nation. It was founded in 1828 by Dr. Milton Anthony and his pupil, Dr. Joseph Eve. The old building was the first permanent site for the school, constructed in 1835 on land leased from the Academy of Richmond County. It served as a teaching facility throughout the antebellum period, was closed temporarily during the Civil War, and was then reopened in 1865 and remained the principal building of importance to the Medical College until 1912.

**W**ith the Restoration Project that the Medical College of Georgia Alumni Foundation has embarked upon, the building will be restored to its prime condition with improved acoustics and audio-visual equipment in the interior so as to accommodate conferences and seminars for up to 300 people. It will also be used as classroom facilities and conferences rooms as well as for local civic projects, such as parties or concerts. Medical history displays will be placed throughout the building to underscore its role as a monument and its place in medical education and health sciences in the South.

The Foundation has retained consultants with extensive experience in historic preservation to initiate this project. The building has been judged structurally sound with well-secured foundations, and

will probably survive for centuries to come if contributions can be raised toward its renovation in the next 2 years. Included in the project will be the rewiring, replumbing, sprinklers, air conditioning and heating, installation of audio-visual systems, new floors, wall repairs, new light fixtures, new stairs, elevator, reopening of the original rotunda, and renovation of kitchens available. New roof, gutters, and stucco and exterior waterproofing will be provided, as well as original landscaping. An adjacent lot has been contracted for parking. Furniture, draperies, painting, and other interior design work will be included.

**R**arely have the physicians in the state of Georgia had an opportunity to participate in the restoration and preservation of a more significant landmark in the history of medicine in Georgia. Landmark donors of \$2,500 or more will be recognized in bronze on a master plaque in the foyer. There is no more fitting way for a physician to thank the medical profession for all that it has meant to him than to participate in this Restoration Project. The Project also offers the family or friends of physicians to honor them by securing their names on the master plaque. There are numerous rooms and projects available within the building that will also provide a



## The Crawford W. Long Medical Museum

naming opportunity for those wishing to honor someone with a more sizable donation. These include the main auditorium, solarium, rotunda, theater, and conference rooms. Donations may be spread out over a 2-year period. Information regarding this may be obtained from the Medical College of Georgia Foundation, EA-100, Augusta, GA 30912; (404) 721-4001.

We know not what the future of medicine holds in the state of Georgia. We do know, however, the pride that we can have in our history of medicine. It is hoped that all physicians who want to be a part of this history will avail themselves of this opportunity. At the present time, over \$700,000 has been raised. Our goal is \$2,000,000. Your contribution may be the one that puts this project over the top. Act now! ■

*William C. Collins, M.D.  
Vice President, MCG Foundation  
Chairman, MAG Board of Directors*

**T**HE CRAWFORD W. LONG MEDICAL MUSEUM in Jefferson, Georgia, is a reminder of medical history in the making, and the article by Dr. Hammonds and Mr. Davis in this issue brings it to our attention once again. I recently visited the Museum and left with a renewed appreciation of Dr. Long, as well as of those individuals who have been involved in the Museum's founding, its development, and its maintenance. That maintenance is supported in part by MAG members who have an opportunity each year to contribute \$10 to the Museum through their annual MAG dues statements. (The deliberations of Reference Committee F at the 1987 MAG Annual Session included a discussion of increasing MAG's financial support beyond the \$10 on MAG statements.)

**N**ow plans for expansion of the Museum are underway. We may, of course, make individual donations to the project. As part of the expansion, a doctor's office and drugstore of the mid Nineteenth Century will be featured. The close relation between Jackson County, the community of Jefferson, and the Museum will be emphasized in new exhibits as well. Donated items are needed, including a desk, a bookcase, chairs, tables, hat tree, lamps, saddlebags, medical and surgical instruments,

apothecary scales, mortar and pestle, home medicine chest, stove and pipes, show globes, apothecary bottles, apothecary jars, vials, pill boxes and bottles, along with other memorabilia. Possibly some documents, photographs, and other artifacts from the 1800s and early 1900s could be used.

Contact the Crawford W. Long Museum, College Street, Jefferson, Georgia 30549, if you have questions. The phone number is 404-368-5307. Our support will be a way for MAG members and friends to be a part of medical history.

*Irving D. Hellenga, M.D.  
Family Practitioner  
Toccoa*

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# The Crawford W. Long Museum — A Tribute to Physicians’ Support and Generosity

William D. Hammonds, M.D., Stephen Davis, Ph.D.

**M**ANY GEORGIANS KNOW of the famous medical discovery made by Dr. Crawford Long of Jefferson, Georgia, more than a century ago. Most physicians are certainly aware of Dr. Long’s pioneering use of ether as a surgical anesthetic. But many doctors may be unaware that a museum in Jefferson, largely supported by MAG members’ voluntary donations, perpetuates the memory of Crawford Long and celebrates his achievement.

We think it’s time for our *Journal* to call attention once again to the Crawford Long Museum, and especially to highlight the generous financial contributions being made by MAG members, which have helped sustain the Museum for the last 12 years. All in all, this is a story in which Georgia physicians may justly take much pride.

\* \* \*

**J**efferson, Georgia, some 65 miles northeast of Atlanta, is a town of 2000-plus people. It was much smaller back in 1841, when 25-year-old Crawford W. Long,

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***In 1976, MAG’s House of Delegates approved a resolution requesting that an item be added to the annual membership dues statement to allow MAG members to donate \$10 yearly as “Contribution to the Crawford W. Long Museum Association.” Since then physicians’ generosity has helped support the Museum.***

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M.D., recent graduate of the University of Pennsylvania Medical School, bought an office near the center of town and began his practice as physician and pharmacist.

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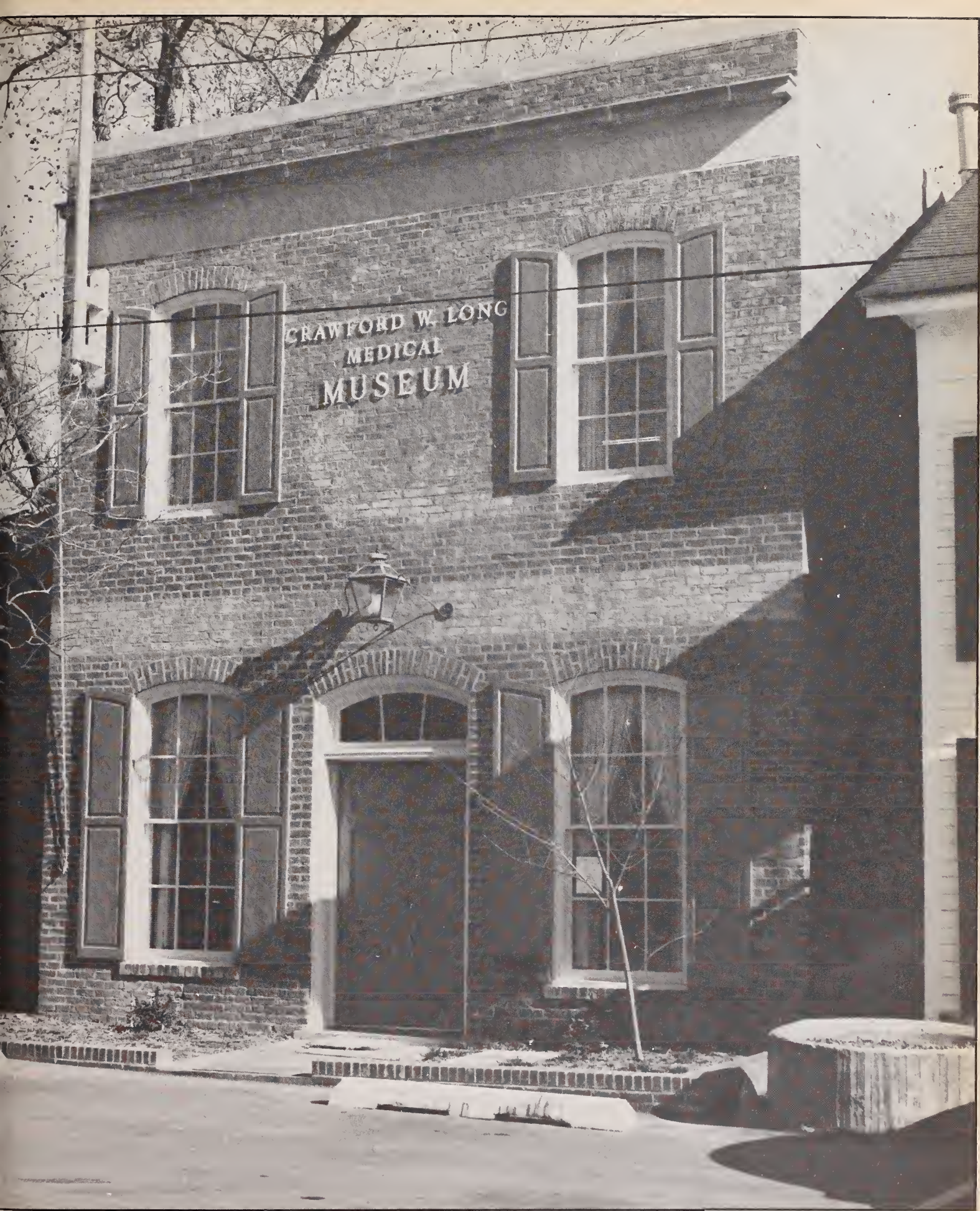
Dr. Hammonds practices anesthesiology in Atlanta, and Dr. Davis is MAG’s Director of Education. Both serve on the Board of Directors of the Crawford W. Long Museum. Send reprint requests to Dr. Davis, 938 Peachtree St., Atlanta, GA 30309.

Long was thus a young country doctor when one of his patients, James Venable, came to him and asked him to remove a tumor from his neck.

Here was history’s opportunity. Long, who knew the exhilarating effects of inhaling ether and nitrous oxide gas at “laughing gas parties” — he had inhaled ether himself and observed its properties — also must have known ether would dull the subject’s consciousness.

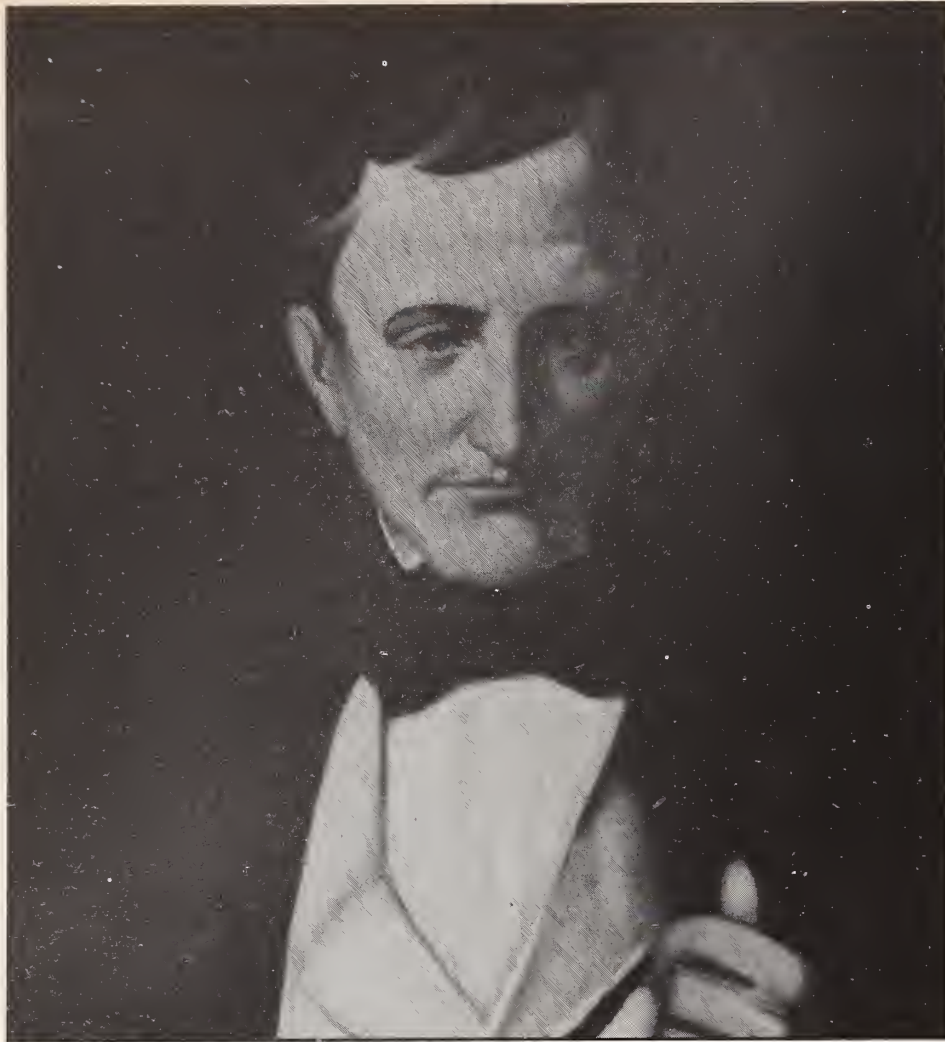
Reasoning that ether would mask the pain of surgery, Dr. Long therefore decided upon the use of the gas during the excision. The operation, performed March 30, 1842, in Long’s office, was a success: Venable was given sulphuric ether on a towel to inhale during the procedure, and afterward said he neither experienced pain nor remembered the event. “When informed it was over,” Long reported later, the “patient seemed incredulous, until the tumor was shown him. He gave no evidence of suffering during the operation, and assured me, after it was over,





*THE CRAWFORD LONG MUSEUM at Jefferson, Georgia, is based in a two-story brick structure, built in the 1860s on the site of Dr. Long's office building in Jefferson. About an hour's drive from Atlanta, the Museum facility has recently been expanded to include the buildings on both sides. Official dedication ceremonies will be held later this Spring.*





DR. CRAWFORD W. LONG, as painted by Lewis C. Gregg. This work, on loan from the Atlanta Historical Society, is on display at the Museum in Jefferson. The portrait is one of a series of 31 paintings of famous Georgians by Gregg. A copy of this likeness hangs in the Academy of Medicine, headquarters of the Medical Association of Atlanta, on West Peachtree Street.

that he did not experience the slightest degree of pain from its performance."<sup>1</sup>

With this episode, surgical anesthesia was discovered — a landmark in medicine which should have brought Crawford Long's name swiftly to the attention of the scientific world. But as an isolated rural practitioner, Long took no immediate steps to broadcast his discovery, which he apparently viewed at the time as one of the details of everyday practice. So, at least, was the manner in which Long entered the procedure in his account book: "James Venable/March 30 — Ether and exsecting tumour . . . \$2." (Today, one might note, surgery and general anesthesia for resection of a neck tumor might typically bring charges of \$1000.)

\* \* \*

The rest of the story is more familiar to us: how the Boston dentist William T. G. Morton claimed credit for the discovery of surgical anesthesia after he removed a tooth from an etherized patient on September 30, 1846; how Morton, Jackson, and Wells competed for patent rights and credit for the discovery; and how Long belatedly entered the controversy, claiming his original use of the anesthetic.

Georgia physicians never doubted Long's claim, though the debate over the discovery continued after Dr. Long's death in 1878. In 1910, officers of the Medical Association of Georgia unveiled a monument to Long on the Jefferson town square, donated by Dr. L. G. Hardman of nearby Commerce. Inscriptions on the granite obelisk emphasize Long as "the

first discoverer of anesthesia" and proclaim:

SULPHURIC ETHER  
ANESTHESIA  
WAS DISCOVERED BY  
DR. CRAWFORD W. LONG,  
ON MARCH 30, 1842,  
AT JEFFERSON, GA.,  
AND ADMINISTERED TO  
JAMES M. VENABLE,  
FOR THE REMOVAL OF A TUMOR.

Eventually, the weight of evidence, especially affidavits from witnesses collected by Dr. Long after his landmark operation, swayed the verdict of history toward the doctor from Jefferson. In 1926, a marble statue of Long was unveiled in Statuary Hall of the national Capitol, and in 1940, the U.S. Post Office released a two-cent stamp commemorating Long as the discoverer of anesthesia. On April 8, of that year, the stamp's first day of issue, a crowd of thousands jammed the town square of Jefferson as Dr. Frank K. Boland of Atlanta, Past President of the MAG, introduced the distinguished guests, including the main speaker, Postmaster General James Farley.

\* \* \*

Amid this acclaim the people of Jefferson recognized the need for a fitting memorial to Long. In 1952, residents of Jackson County formed the Crawford W. Long Museum Association for the purpose of raising funds to buy the property where the doctor's office once stood. By then, the two-story frame office had been replaced by a brick store, built in the 1860s. With the help of some state funds, the Museum Association purchased the building, and in 1957 the Crawford W. Long Medical Museum opened under operation by the Georgia Historical Commission.

Since then, the Museum has undergone growth and some growing pains as well. In 1973, the Historical Commission decided to close the facility and was preparing to haul its artifacts and Long memorabilia to Atlanta when the





DOMINANT FEATURE of the Crawford Long Museum is this diorama depicting Dr. Long's use of ether as he removed a tumor from the neck of James Venable on March 30, 1846. A committee of historical experts, which included Dr. Lester Rumble, Jr., of Atlanta, saw its design, ensuring, for instance, the construction of authentic-looking desk, table, bookcase. Residents of Jefferson provided information on the stagecoach, shown through doorway of Dr. Long's office, as it would have appeared in front of the Harrison Hotel.

townspeople of Jefferson rallied. They persuaded the Governor to give ownership of the building to the city, and allow local citizens to operate the museum. Some operating funds were given by the city government, but visitors' donations to the Museum remained critical to its continued operation.

"We were just kind of rocking along, taking in money at the door," says Tom Bryan, President of the Museum Association. Then, in 1976, Atlanta anesthesiologists Evan Frederickson, M.D., and John Steinhaus, M.D., Ph.D., decided to stir physician support for the Museum. The Georgia Society of Anesthesiologists began to make regular contributions; then it asked

the Medical Association of Georgia to establish a system for MAG members to do the same. In April, 1976, Thomas L. Tidmore, Jr., M.D., speaking for the Georgia Society of Anesthesiologists, introduced a resolution to the MAG House of Delegates requesting that an item be added to the annual membership dues statement to allow MAG members to donate \$10 yearly as "Contribution to the Crawford W. Long Museum Association." The House approved; and since then, through their generosity, Georgia physicians have helped the Museum not only thrive but also improve its facility and expand its collection. In 1979, thanks to contributions by the

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***"When informed it [the operation] was over," Long reported later, "the patient seemed incredulous, until the tumor was shown him. He gave no evidence of suffering during the operation, and assured me, after it was over, that he did not experience the slightest degree of pain from its performance."***

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Georgia Society of Anesthesiologists and the Medical Association of Georgia, the Museum's exhibit areas were renovated and some new displays were added.

\* \* \*

All the work, time, and money show to advantage when you visit the Crawford Long Museum in Jefferson. It is located just a block from the center of town, across from the Long Monument and across the street from (as you would expect) the Crawford W. Long Pharmacy. Inside, handsome exhibits, arranged on the first floor (at the time of our visit) tell the story of Crawford Long: his upbringing in Georgia, his medical practice in Jefferson and subsequent move to Atlanta and Athens, even his service as Confederate hospital physician during the Civil War.

Descendants of Dr. Long have donated a number of his possessions, on view in the Museum's display cases: his pocket medicine case, eyeglasses, the chair he used as a boy, his diploma case from Pennsylvania, his chess pieces. Key documents, reproduced and hung about the walls, reflect Long's illustrious career as physician: his medical school diploma, affidavits from witnesses to Long's use of ether for surgical

anesthesia, a page from his Athens drugstore ledger, his U.S. pardon for having aided the Confederacy. Among the portraits and photographs on display is Lewis Gregg's well known portrait of Long (copies of the painting hang in Atlanta's Academy of Medicine and Crawford Long Hospital). But surely the highlight of the first floor is the colorful diorama recreating Long's famous operation on James Venable. The scene of the doctor's office — complete with equipment, bookcase, desk, and armchair, modeled after period furnishings — is recreated in minute detail. In the corner, Dr. Long is shown at work on the patient, crouched over a chair.

Another area of the Museum is devoted to the development of anesthesia in history. Wall displays explain the medical conquest of pain, from early times to more modern techniques. Methods of inhalation anesthesia are strikingly exemplified by actual machines on display: Connell's Anesthetometer, the device developed in 1913 to measure and mix

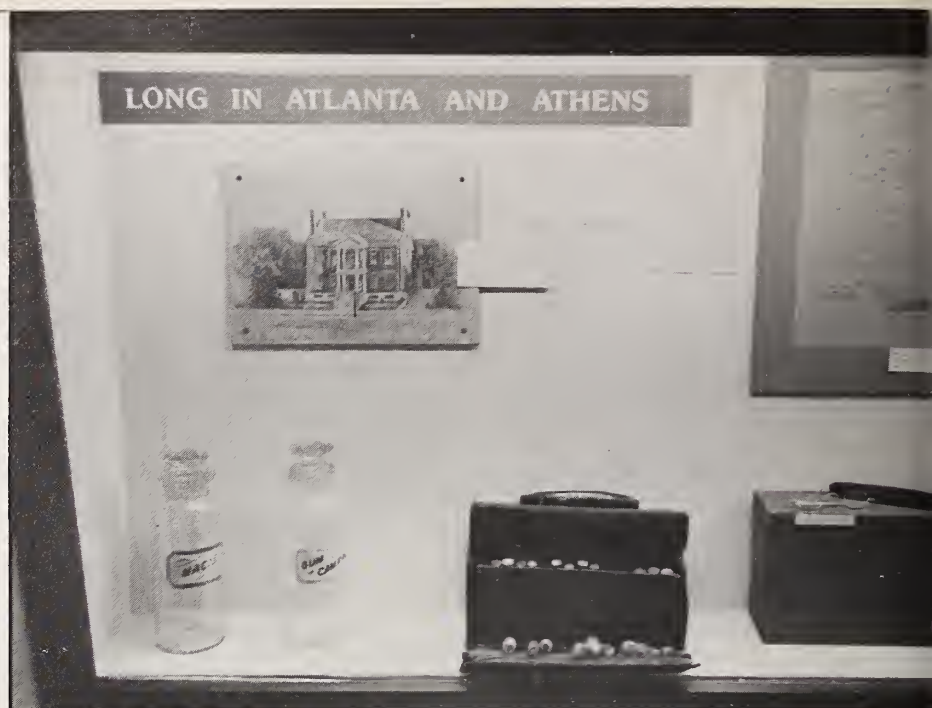
ether vapors and gases in accurate concentrations; Heidbrink's nitrous oxide/oxygen apparatus from the 1920s; Richard von For-egger's apparatus with flow meter (1936). A contemporary anesthesia machine is also shown, cut away to reveal its inner workings.

\* \* \*

With all this going for it, the Crawford W. Long Medical Museum aspires to even more. A new fund drive for expansion has begun, with the Museum Association soliciting contributions from Jackson County residents and businesses. The Georgia Society of Anesthesiologists recently donated \$5000 to the project. But Association President Bryan makes it clear that individual physicians' donations are crucial.

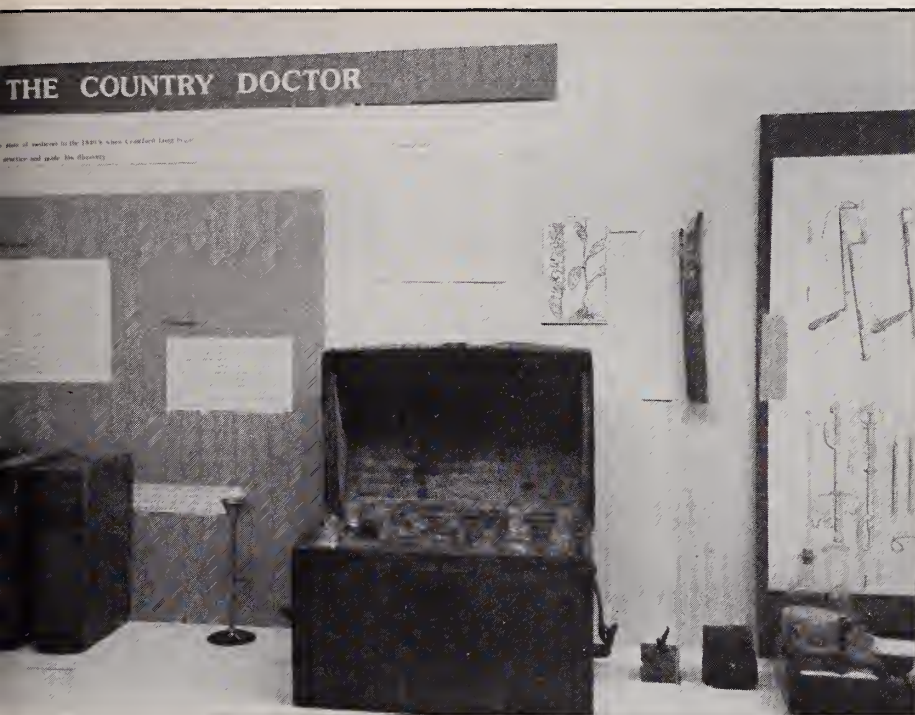
"We deeply appreciate the doctors' generosity," says Bryan. "Without those dollars, we wouldn't be anywhere near considering this expansion."

For the expanded Museum, which officially opened January 31, 1988, the two buildings on each side of the original structure have



*A DISPLAY CASE at the Long Museum. As stated in Dr. Irving Hellenga's editorial for this issue (p. 85), the expanded Crawford W. Long Medical Museum is asking Georgia physicians for contributions of medical instruments, texts, and apothecary supplies from the mid-nineteenth century. The Museum's displays seek to convey the state of medicine as practiced by Dr. Long in Jefferson during the 1840s.*





*ON DISPLAY at the Crawford W. Long Medical Museum in Jefferson are Dr. Long's medicine case, glasses, and a ledger page from his drugstore in Athens, 1861. Long moved to Atlanta with his family from Jefferson in 1850, but the next year moved again to Athens, where he resided until his death in 1878. Dr. Long's grave at Oconee Hill Cemetery in Athens has recently been placed in perpetual care through financial contributions from the Georgia Society of Anesthesiologists and the Crawford W. Long Medical Society.*

been bought and remodelled into a single historical complex. "We want to give a feeling for Dr. Long's time and life in north Georgia back in the 1840s," says Bryan, "so we can emphasize the importance of his discovery. Medical equipment, scientific knowledge and communication just weren't very advanced — which makes his discovery all the more dramatic."

Since 1977, Georgia physicians have contributed over \$108,000 to the Long Museum — a remarkable display of professional philanthropy. Mr. Bryan wants all MAG members to know how appreciative the Association is, but also how hopeful he remains that MAG's physicians can continue giving to the cause. Expansion of the Museum building, new furnishings, acquisition of still more historical and medical artifacts, not to mention maintenance and professional staffing, will place increasing pressure on the Museum's extremely modest budget. "I hope that all MAG members will consider making an annual contribution," adds Bryan. "Consid-

ering all the work in store for us to build a better Museum, we'll need every dollar." Eighty thousand dollars, in fact, are needed to complete the expanded building alone.

\* \* \*

**D**r. Crawford W. Long left a distinguished legacy to medicine. His contributions were accepted first by his colleagues in the South and then slowly acceptance was granted to him outside his native region. History seemed to vindicate Long, however. Morton, Jackson, and Wells, all of whom claimed to have discovered anesthesia, died tragic deaths. Morton was reduced to poverty by the long controversy and litigation over the right to a patent for anesthesia. He died from apoplexy a bitter man.<sup>2</sup> Wells committed suicide while in jail in 1848. He was distraught because his claim to have discovered anesthesia was not accepted.<sup>3</sup> Jackson became insane during his controversy over the discovery of anesthesia and finished his days in an

asylum.<sup>4</sup> Crawford W. Long lived a useful and productive life as a practicing physician and surgeon. He died in 1878 of a stroke while administering ether to a young patient in labor. It is said that when afflicted Long fell forward onto the patient's bed and in the best tradition of medicine, his last words were: "care for the mother and child first."<sup>5</sup> Thus, the Medical Association of Georgia has reason to be proud of the legacy of Crawford W. Long and the museum in Jefferson which helps to preserve that legacy. We think that physicians' sustained giving is more than worthwhile — it is a measure of pride in our state's history, and in the heritage of Georgia's medical profession.

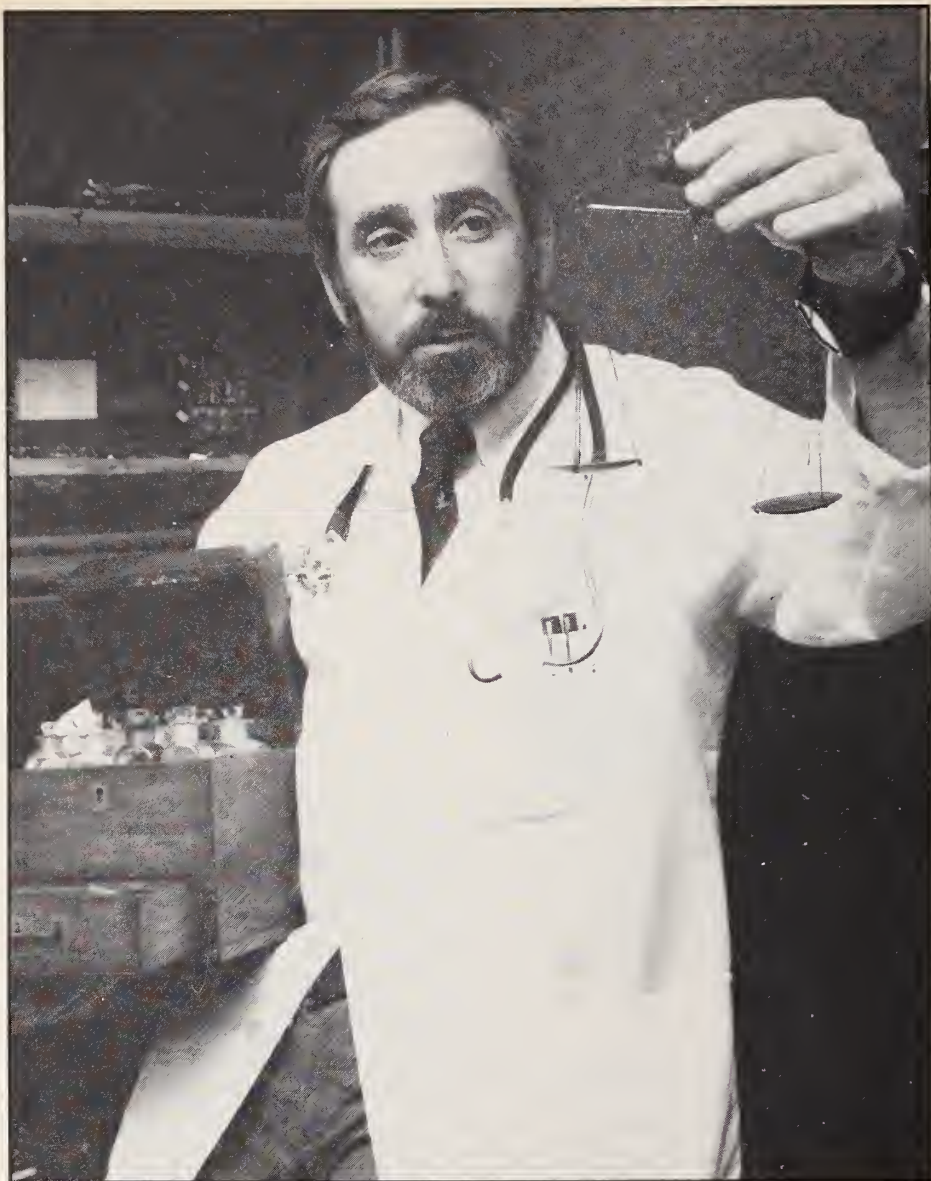
### Acknowledgement

The authors would like to express their appreciation to Ms. Susan Deaver of Atlanta for her contributions to this article.

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# Collecting Antique Medical Instruments

Stephen Davis, Ph.D.

*DR. LAURENCE (LANNY) LESSER, cardiologist in Gwinnett County, has been collecting medical antiques for only 5 to 6 years. To look at all of the instruments, vials, and other paraphernalia around his office, one would have suspected a collector of many, many years.*

**“We contacted two physicians who have private collections of medical antiquities and quickly found that each owner’s pride in rare, valuable things was infectious as we came to share his excitement.”**

**N**OTHING SHOWS THE TECHNICAL advances of modern medicine more clearly than the antiquated relics of yesterday’s medical practice.

You may see them from time to time. In Atlanta, the Emory Medical School Library has a fine collection, including nineteenth-century surgical instrument kits (we displayed one of them on the cover of *JMAG* January 1986). Crawford W. Long Memorial, St. Joseph’s and other metropolitan hospitals have a number of old medical devices.

But there are several private collections, too, owned by physicians who are enthusiastic acquirers of medical antiquities. We contacted two of them in Atlanta,

and with each had a very enjoyable visit. We quickly found that each owner’s pride in rare, valuable things was infectious as we came to share his excitement over the acquisitions. Plenty of stories were told of how he found this item or how that machine worked. Along the way we learned quite a bit about how physicians and surgeons *used* to care for their patients. (In all cases we were heartily relieved that medicine has progressed so much.)

Dr. Davis is Associate Editor and Book Review Editor for *Blue and Gray*, a magazine for Civil War buffs. He serves on the editorial board of the *Atlanta History*, published by the Atlanta Historical Society. Dr. Davis is also *MAG*’s Director of Education. Send reprint requests to him at 938 Peachtree St., Atlanta, GA 30309.



**P**atients walking into the reception area of Dr. Laurence Lesser's cardiology office in Snellville are immediately struck by the atmosphere of a bygone era. Hanging all around the walls are framed color prints out of *Vanity Fair* Magazine, dating from the 1880s and '90s. On one chair-side table sit a brass hour glass and a charmingly decorative magnifying glass. On another, a quaint daguerrotype preserves the images of a man and woman in a primitive photograph taken probably 150 years ago.

Over to the side is a polished wooden cabinet on whose shelves are displayed an ether dispensing jar and "Dr. Nelson's Improved Inhaler." A leather-lined medicine box is opened to show four dozen glass medicine bottles. The traditional mortar and pestle are nearby. Beyond this, in a corner, stands another big cabinet loaded with aged medicine bottles, each labeled so arcanelly that one would have to consult a volume of *Materia Medica* from the 1880s just to figure out what the names mean: "OL. CAJUPUT," "OL. TANACETI," "SP. CITRON.," "PIP: PULV: CAPSICI," "SAL PRUNELLAE." Bottles for digitalis and belladonna were at least a little more familiar. There were some brand-name medications, too, such as "Herbine" and "Dr. Kilmer's Swamp Root" (a diuretic). We noted the high alcoholic content of a number of these

medicines; "Rich-Lax" was in effect a twelve-proof laxative. "Musk Root" contained a whopping 65% alcohol. (Not surprisingly, its label described the product as "a most valuable nerve stimulant.") An antique brass microscope, a leather band holding scalpels and scissors, and other professional accoutrements all help to convey the impression that Dr. Lesser is a physician with a firm fix on the history of medicine.

It gets even better walking down the hall toward his office. On the right is a glass-enclosed shelf with four surgical instruments, whose purposes were too obscure for us to surmise. On the left, another frame-box holds two Civil War-era saws: an ivory-handled cutter with a brass blade ornamented by, of all things, a dolphin's head; and another with a handle of ebonized wood. Dr. Lesser told us later it was English-made and, though it

bore finer, gentler-looking saw-teeth than the other blade, its name seemed gruesome enough: a "Dr. Butcher saw."

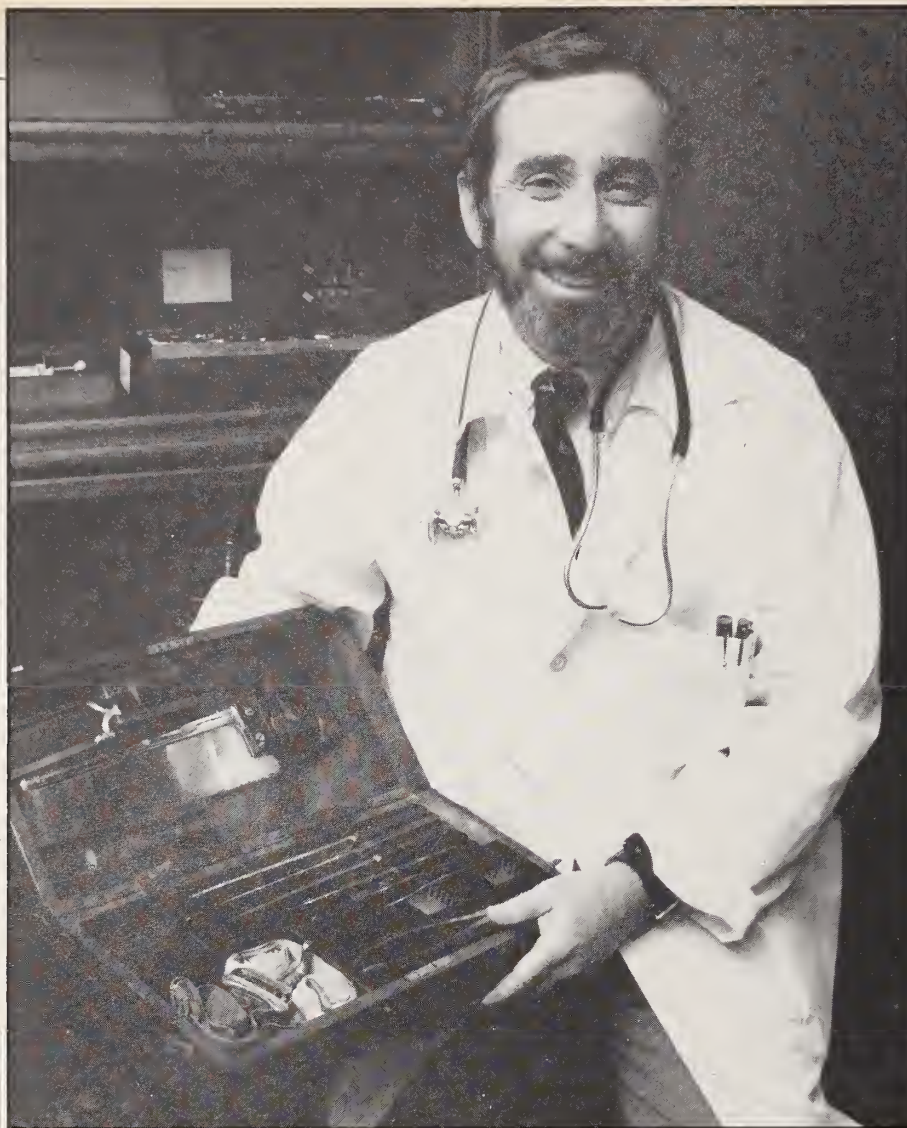
We asked Dr. Lesser if his patients objected to these old relics lying about, whether they were perhaps frightened by them. "Oh no," he said, "Actually, there is a feeling of relief that we've gotten beyond those practices, and it makes our treatment and recommendations seem tame by comparison."

**A**ll the artifacts outside provide just a hint of what his office looks like. To one side, a towering wooden chest, formerly belonging to a physician in Thomaston, Georgia, brims with items. Dr. Lesser describes each with clearly evident enthusiasm. "Look at these surgical kits," he said, "and try to figure out which ones were used before the onset of sterilization." He pointed out the ma-

*IN THE RECEPTION AREA of his office, Dr. Lesser has these items on display, from a bygone era: W. B. Spencer's Neuralgia Mixture, an old brass microscope, a leather scalpel and scissors kit, and plenty of old medicine bottles — one of them, in the lower right, contained "Elixir Iodo-Bromide of Calcium," whose alcohol content was 20%. What a popular prescription item it must have been!*







*ANOTHER MEDICAL ANTIQUITY, with its proud owner. We learned much about medical history in visiting Dr. Lesser's office. The Civil War surgeon's kit, shown here, for instance, obviously preceded the age of antiseptics — the wooden handled instruments would have been impossible to sterilize.*

used when the physician suspected a subdural hematoma. Screwing four burr holes into the skull (he showed us devices for each of these steps), the doctor would then use a Heys Saw to connect the holes and lift up the flap of skull. "If he were rewarded, the subdural would then present itself with a splash of bloody fluid, and the physician would congratulate himself that he had saved a patient who would otherwise surely have died." Unfortunately, trephining was used too commonly, more often than not on a patient who eventually showed no hematoma. Because the patient died as a rule from the severe procedure, trephining fell out of favor during the Civil War.

As Dr. Lesser described this piece of equipment or that, among the many he has in his office, they all began to blur together, much like the displays of a large museum after an extensive tour. Civil War bullet probe, late nineteenth-century brass microscope, apothecary scale, O'Dwyer intubator, early surgical sterilizer, U.S. Navy

jor difference. On one shelf was a mid-nineteenth century amputation set. The key lay in the handles of ebonized wood. "They were impossible to sterilize; but look at these," he said, pointing to a World War I British surgeon's kit. All the instruments were of stainless steel, easily sterilized. Also, there were many more tools, not just cutters, reflecting the expansion and increased complexity of surgical techniques between the Civil War and World War I.

Dr. Lesser pointed to the other notable items. One group, dating from the 1850s, was an English purging device with all the equipment needed to induce vomiting: a mouth-gag; an ivory-handled, brass syringe; and gutta serena rubber tubes. Through these, pur-

gatives such as calomel (a mercurial poison) were administered to cause vomiting and diarrhea. Still more implements were used for enemas and douches. "Of course they were never sterilized, and were probably used interchangeably," Dr. Lesser noted.

Equally archaic was a "cupping set," dating from the days when bleeding a patient (to allow efflux of a body's "bad humors") constituted approved medical practice. Various devices were used to raise a blister on the skin; then was applied the "scarificator," which operated as scarily as it sounds. (With a flick of a little knob, multiple razor blades would pop out of the bottom.)

Then there was trephining. Dr. Lesser explained the procedure,





post mortem kit, 1830 ophthalmoscope; they're all there, each drawing forth a story from the proud owner. Thus, the Bruton otoscope (ca. 1850), which solved the problem of illumination with an aperture in the side of the tube to let in candle light; an interior mirror reflected it into the patient's ear. He's even got an old, rather peculiarly shaped ceramic bed pan. "I've been thinking of growing a plant in it," he said, "but I'm afraid someone might get offended."

**H**ow long has he been collecting medical antiques? We were surprised: "Oh, about 5 or 6 years. I've always been interested in medical history, especially the history of cardiology. The old theories of medicine, the antiquated-sounding, yet very precise clinical terms are intriguing." He pointed to a century-old anatomical atlas, with carefully drawn diagrams, and read to us an example of a case description from its brittle, yellowing pages. Maybe it was this kind of conversation which caused one of his patients

(a 90-year-old retired physician) to give Dr. Lesser his old instruments (including the two saws we observed on the wall) several years ago. Thus was his collection started.

We asked him about his most prized collectibles. "The stethoscopes." Sure enough; they're all around. "I first started collecting monaural stethoscopes," he said, as he pointed to the print on his office wall. It shows the French physician Laennec, at Paris in 1816, using a hollow wooden cylinder pressed against a patient's chest to hear the heart beating. Right next to it, a frame box displays seven of the same kinds of stethoscopic tubes, each made of a different substance — oak, brass, gutta percha, or bakelite (an early plastic). More are down the hall and in the cabinets.

We could have stayed for hours, of course, hearing him talk about his prized objects. Walking toward the door, though, he said, "Oh, I've got to show you this!" From behind his desk out came an imposing wooden box, which

he opened to show a bewildering panel of gadgetry. A black knob in the center was labeled "VOLTAGE CONTROL" and had arrows to the left and right marked "strong" or "mild." Placed delicately in a holder was what looked to be a small six-pronged glass rake, with small wires inside. "It's really a quack device, dating from the 1920s," Dr. Lesser said. It surely had a quackish-sounding name: "RENULIFE VIOLET RAY GENERATOR." Dr. Lesser plugged it in and turned the knob. A faint purple light glowed in the glass extending out into each of its six tubular tines (fingers?). He even has the physician instruction booklet to go along with it. The first page alone promised a world of cures, for abscesses, acne, post-operative adhesions, anemia, arteriosclerosis, asthma ("Treat over the chest and throat glands with electrode No. 1 in light contact. . . .") Just then, one of his nurses walked in. Quipped Dr. Lesser, "Pam gets one of these treatments daily, and it works wonders."

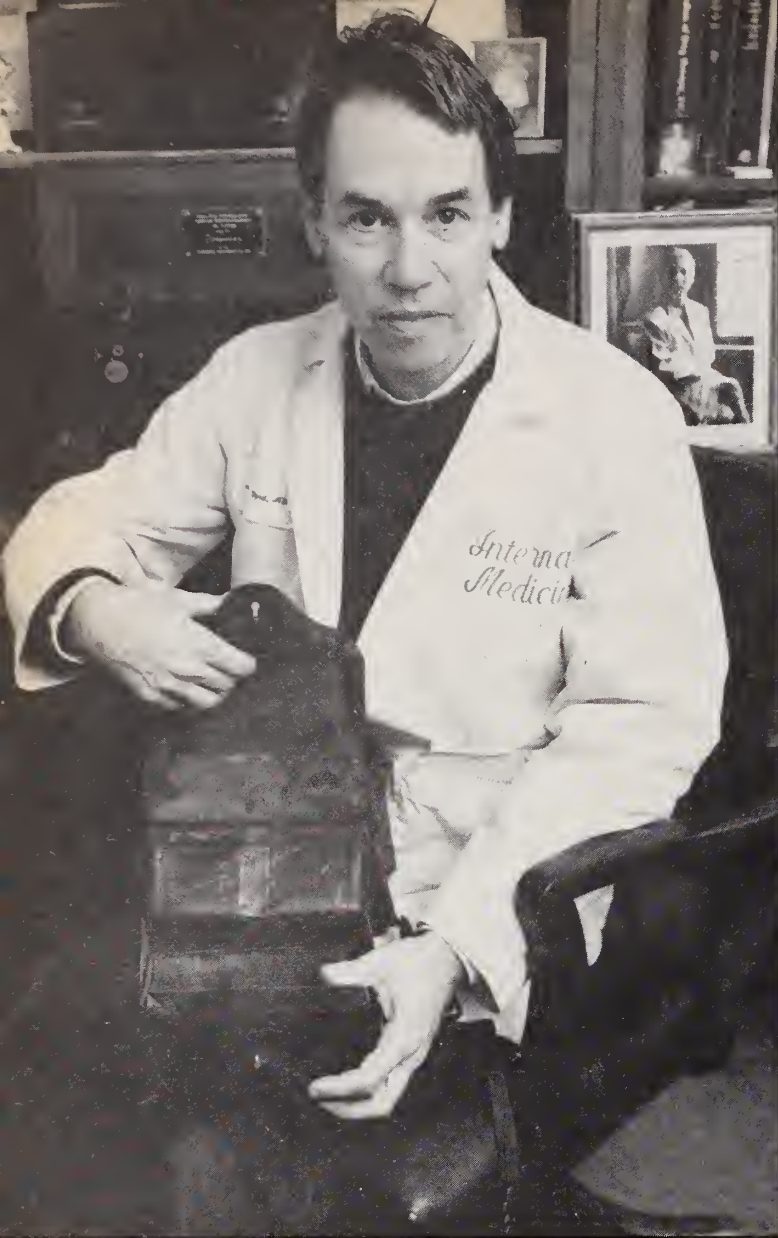
\* \* \*

*PHYSICIANS A CENTURY OR TWO AGO would have employed these instruments, on display in Dr. Lesser's office. Note the fleams in the corner right — sharp blades to cut the skin and allow efflux of disease-causing "humors" to bleed out of an ailing patient. Think how far our medical science has progressed!*

*DR. LESSER with his "Renulife Violet Ray Generator," a pseudo-medical device dating from the 1920s that purportedly cured ailments by applications of electrical current to the skin. "Pam gets one of these treatment daily," he joked as one of his nurses walked in, "and it works wonders."*







**GOOD COLLECTOR** is always eager to show off his prized items. Dr. Byrd is especially fond of his rare medical bags, including a physicians' saddle bag, used to carry instruments and medicines on horseback.



**DR. BYRD DEMONSTRATES** the use of a U.S. field surgeons' kit dating from the turn of the century (note the metal handles: physicians had discovered a few years before that cutting instruments needed to be boiled for sterilization). In the back is the "string galvanometer," an early cardiograph, used by his father, T. Luther Byrd, M.D.

**A**nother collector of medical antiques is Daniel Byrd, M.D., an Atlanta internist. He doesn't really specialize in old instruments; in fact, he doesn't specialize in things medical at all, but collects all sorts of charming relics of the past. "Old clocks and pocket watches are primarily my interest," he says, but Dr. Byrd also has "picked up" a number of fine books, some centuries old. One of his medical texts, dating from 1622, lacked the title page when he bought it. Undaunted, he identified several institutions around the country which held the book

in their libraries, and got Yale Medical Library to send him a facsimile of the missing page, which he inserted into his volume. "Inserted" is not really the right word, for Dr. Byrd is a proficient amateur bookbinder. Once he bought some loose pages of a French scientific encyclopedia printed at Paris in 1762. Determining to make them into a volume, he bought bookmakers' coverboard and rolls of reconstituted leather to fashion his endcovers; he sewed the pages, and made the whole into an attractive oversized folio — complete with the book's title on the

side, blazoned in gold letters which he impressed himself into leather.

Dr. Byrd thus has plenty of *objets* to display, but he shows off his medical antiques with particular pride. In his office, for instance, is a primitive electrocardiograph which his father owned. Called a String Galvanometer, the device recorded heartbeats with a quartz string suspended between electromagnets; its deviations would be recorded on photographic film. At home he's got a nice array of rare medical bags, including a physician's saddle bag,



used to carry instruments and medicines on horseback. One well-preserved leather strap, when unfolded, holds dozens of tiny glass vials, which held the chemicals mixed by a physician or apothecary to make medicines. He showed us an old nickel-plated otoscope, a 1925 blood pressure gauge, a U.S. field surgeon's kit dating from the turn of the century, an exquisite brass microscope manufactured in 1886, and (from the 1700s) a set of metal-framed eyeglasses crafted, Dr. Byrd said, by a "whitesmith" — an obsolete term reflecting an artisan who worked with tin (as opposed to the iron-wielding "blacksmith" and, of course, the "coppersmith").

Then he brought out a set of fleams — little lancets, each sheathed in a folding tortoise-shell cover. They were used back in the days when the physician's art consisted chiefly of draining the ailing patient of blood.

"Everybody's collection ought to have some of these gruesome items," Dr. Byrd said as he picked up a big knife from his cabinet. It was an ebony-handled amputation saw dating from around 1800, with a broad, jagged blade. "It's important to let your patients know we still don't use these things." Then, with a twinkle in his eye, he mock-seriously turned to face an imaginary patient. "Well, Mrs. Jones," he intoned, thwacking the saw against his palm, "I see that we're going to have to remove that finger of yours!"

While Dr. Byrd has acquired a number of his artifacts from professional dealers, he delights most in the items he has casually found at flea markets and bought at bargain prices. Behind his desk, in fact, is a framed piece of calligraphy that seems to serve as his motto: "Beware of bargains in parachutes, life preservers, fire extinguishers, brain surgery, and legal services." (All other bargains, we inferred, are OK.) Thus, he brought forth the old wooden stethoscope

which he bought at an antique flea market for only \$6 — because the dealer mistook the thing for some kind of vase. Better still was the old metal medicine measure, a device that opens like a pocket watch to show little measuring spoons for calibrating dosages. Imprinted on the outside is "Dr. C. H. Fitch's Prescription Scale. Patented Sept. 29, 1885. Manufactured by N. V. Randolph & Co., Richmond, Va." The cost of this little treasure? Dr. Byrd grinned, "I got it for 25 cents at an estate sale."

(Incidentally, Dr. Lesser told us that he doesn't believe Dr. Byrd's stories of these great bargains. "I think he makes them up to make me jealous.")

**B**e that as it may, we came away from our artifactual foray into medical history with a keen appreciation for advances which medicine has made and a lot of enthusiasm for the pursuit of medical antique-collecting. We sincerely appreciate Dr. Lesser's and Dr. Byrd's sharing their time and treasures with us. ■

*SOME OF THE MEDICAL ANTIQUES that caught our eye while visiting in Dr. Dan Byrd's office: the nickel-plated otoscope reflected candlelight from a side aperture to allow the physician to examine a patient's ear; "Dr. C. H. Fitch's Prescription Scale" dates from the 1880s. The case at the bottom holds fleams, sharp-edged blades innocuously sheathed in tortoise-shell; they were used for bloodletting. Beneath all is a page from the French encyclopedia, published at Paris in 1762, which Dr. Byrd rebound himself into an exquisite folio volume.*





# Chronicling the History of MCG:

## An Interview With Dr. Phinizy Spalding

Stephen Davis, Ph.D.

**“YOU NEVER KNOW** exactly where you are going until you can tell where you have been.”

So goes the old saying about history and its usefulness. Recently, faculty and alumni of the Medical College of Georgia have been able to tell more clearly where their institution has been, thanks to a prodigious — and at times controversial — new history. Last year, *The History of the Medical College of Georgia* was published by the University of Georgia Press. Reflecting nearly a decade of research and writing by author Phinizy Spalding, the long-awaited book has put the institution's past in well-reasoned perspective.

The perspective is a long one, going back to 1828, when the college was chartered as the Medical Academy of Georgia. It opened the next year somewhat inauspiciously with seven students, no facility except the city hospital in Augusta, and a faculty of three professors.

One of them, Milton Antony, was the dynamo behind the activity. It's clear from reading Professor Spalding's book that Antony is one of the real heroes of MCG's story. "I admire him as being an event-maker," Spalding told us in a recent interview. "I think once he got this bee in his bonnet about doing something for medical education in the South, there was no stopping him."

But Georgia in the 1820s was hardly a propitious land for sowing the seeds of higher education. Little more than a frontier state, save the narrow strip of civilization up and down the Savannah River and along the Atlantic coast, Georgia had just rid herself of the Creek Indians west of the Flint River. Cherokees still held the land north of the Chattahoochee. Sheer taming of the land was bound to make more sense at the time than the training of physicians. "I'm convinced," says Spalding, "that when Antony thought to present the state legislature with the idea of chartering a full-fledged medical college, from the very beginning he must have doubted whether the enterprise would succeed."

But the enterprise grew, and grew quickly in the early years. Funding was solidified; curriculum was strengthened; and the faculty attracted some of Georgia's ablest physicians. Among them were Paul F. Eve, first Georgian to become president of the American Medical Association, and his brother Joseph; Lewis D. Ford (twice mayor of Augusta, first dean of the College, and eventually the first president of MAG), and Louis A. Dugas, Antony's tireless collaborator who helped establish MCG's medical library. By 1837, the college had its own building, an imposing Greek-revival structure on Telfair Street, and even a scholarly publication, the *Southern Medical and Surgical Journal*.

Incidentally, Professor Spalding believes that a temporary lapse in publication of *SMSJ*, during 1839-45, may have denied Dr. Crawford W. Long

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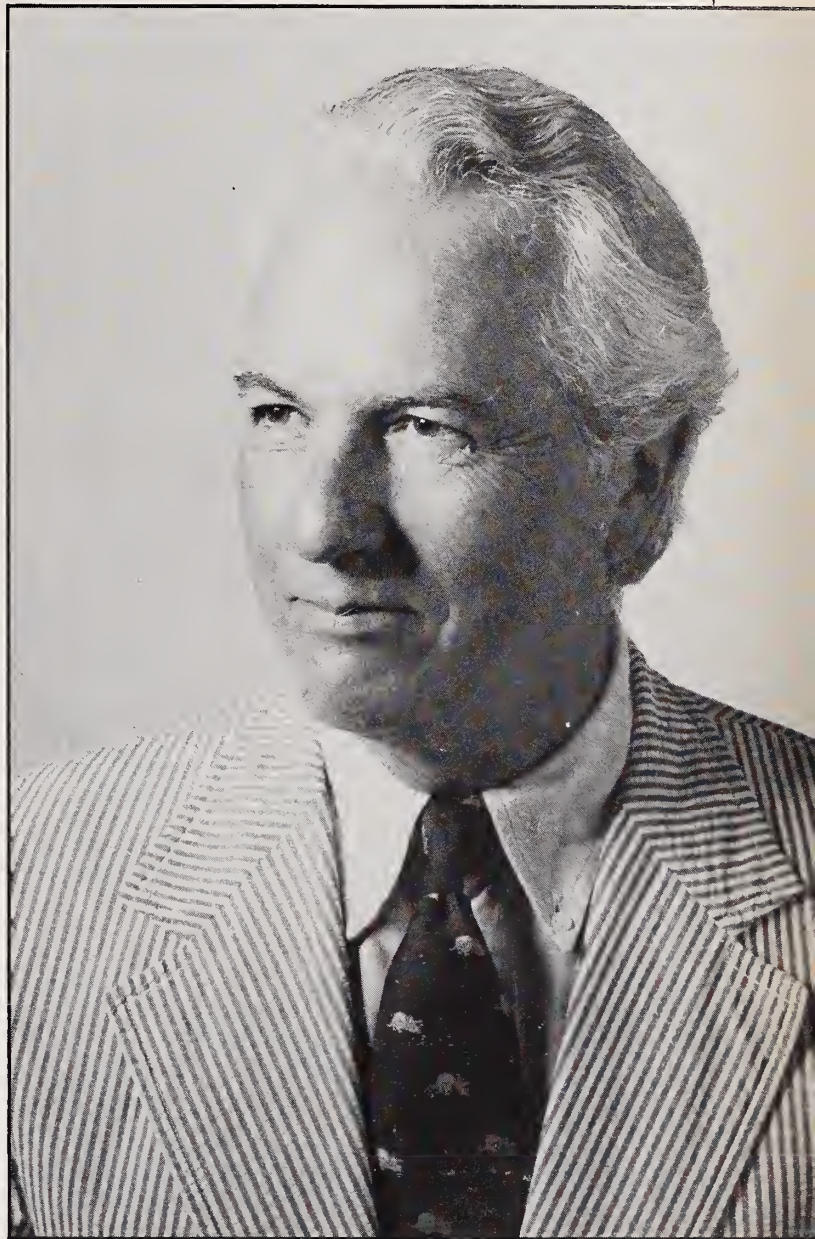
Dr. Davis is MAG's Director of Education. Send reprint requests to him at 938 Peachtree St., Atlanta, GA 30309.



**“I’m convinced that when Antony thought to present the state legislature with the idea of chartering a full-fledged medical college, from the very beginning he must have doubted whether the enterprise would succeed.”**

in Jefferson the opportunity he needed to publicize his innovative use of ether in 1842. Some Long scholars don’t believe that the country doctor would have been inclined to publish, even if the *Augusta Journal* had been operating; but given the controversy to this day over credit for first surgical use of anesthetics, Dr. Spalding’s speculation is an arresting one.

**T**he 1830s and ’40s was a time of ferment in American medical education. Back then, admission standards among the nation’s 37 medical schools were notoriously lax, and the school curriculum required only 2 years, with terms varying from a mere 4 to 6 months. Educators around the country began calling for reform, and MCG’s leadership spoke out loudly for longer terms and high standards. (It was largely as a catalyst for educational reform that the American Medical Association was organized in 1848.) In actuality, however, since medical colleges were generally proprietary and depended almost exclusively upon tuition fees, stringent standards for selecting students frequently gave way, as Spalding states in his book, to “personal, emotional, and financial considerations.” Thus, while MCG rose to sectional eminence in the years before the Civil War and boasted large graduating classes, financial considerations remained paramount. Competition from newer schools in Georgia and Alabama, especially the proliferating “diploma mills,” forced Medical College officials to back-track on some of their calls for academic improvement.



*HISTORY PROFESSOR PHINIZY SPALDING of the University of Georgia is author of The History of the Medical College of Georgia, published last year. A native of Atlanta, he is a graduate of the University of Georgia and the University of North Carolina at Chapel Hill, where he earned his doctorate in Colonial American history. A member of the faculty in Athens since 1966, Dr. Spalding is author of Oglethorpe: A Brief Biography and Oglethorpe in America, and numerous other works. For many years he also served as Editor of the Georgia Historical Quarterly.*

But the worst was yet to come after the Civil War. Struggling for students and cutting corners, the Augusta institution saw key faculty members leave and its *Journal* quietly die. Financial hardship from shrinking student pools was coupled by state cutbacks, even though the Medical College had officially become part of the University



of Georgia in 1873. Professors' efforts to preserve income and perquisites led to debilitating faculty in-fighting. "The idealistic fervor of the past was gone," notes Spalding sadly; for decades after the 1870s, "the business ethic, with its emphasis on profit and material values, was triumphant." Under these dubious conditions, prosperity eventually returned to MCG, but curricular innovation and academic excellence did not. "MCG withdrew into a protective shell after the Civil War."

***“Eugene Foster [dean of MCG in the 1890s] realized that the Medical College was falling behind in the areas of American medical education, and he instituted a number of reforms which I am convinced permitted it to survive the strictures that Abraham Flexner laid on it in 1910.”***

**W**e asked Professor Spalding which era of MCG's history interested him most; he said it was the 1890s. "I think that period was quite fascinating because it was a time of such change in American medicine and in American medical education. Johns Hopkins was just getting started and beginning to have enormous impact on the curriculum. The Medical College's dean at the time was Eugene Foster, who I think is one of the unsung heroes of MCG. He was acutely aware of what was going on at the national scene. You see, by the 1890s the Medical College had become very inbred [in his book, Spalding speaks of professors "who thought of faculty positions at the school as personal property to be handed down like heirlooms"]. Foster understood this and knew it was going to cause the College major difficulties. The quality of instruction had dropped badly. Professors were not holding clinics the way they should have been, sometimes absenting themselves simply on whim. Foster realized that the Medical College was falling behind in key areas of American medical education, and he instituted a number of reforms which I am convinced permitted it to survive the strictures that Abraham Flexner laid on it in 1910."

**T**he Flexner Report, an impartial, no-holds-barred analysis of U.S. medical schools,



*THE NEWTON BUILDING, home of MCG, 1913-54, formerly the Augusta Orphan Asylum. This structure served as the College's second home after the Cluskey Building.*

struck the College in Augusta like a bolt of lightning. Especially jarring was its advice to the University System that it cut all ties to MCG: "Snap the slender thread; the Medical School will not long survive the amputation." Flexner's criticisms, coupled by subsequent censure by national accreditors, jolted the Medical College. The school's leaders, its supporters in the Augusta community, and its friends in the state legislature banded together to bring MCG into the modern era. The curriculum was modernized, equipment and facilities improved, entrance criteria stiffened, national and local funding grants obtained. Many of these achievements were begun by the vigorous dean of MCG from 1910 to 1923, William H. Doughty, Jr. Other leaders such as George Lombard Kelly saw that the Medical College expanded with new buildings and new professional schools. To the School of Medicine were added those of Graduate Studies (1951), Nursing (1956), Dentistry (1966) and Allied Health (1968). As a result of this remarkable activity — what a change from the dark days at the turn of the century! — the Medical College of Georgia today can boast of an 8-acre campus with four dozen buildings, 2600 students, 4000 faculty and staff.

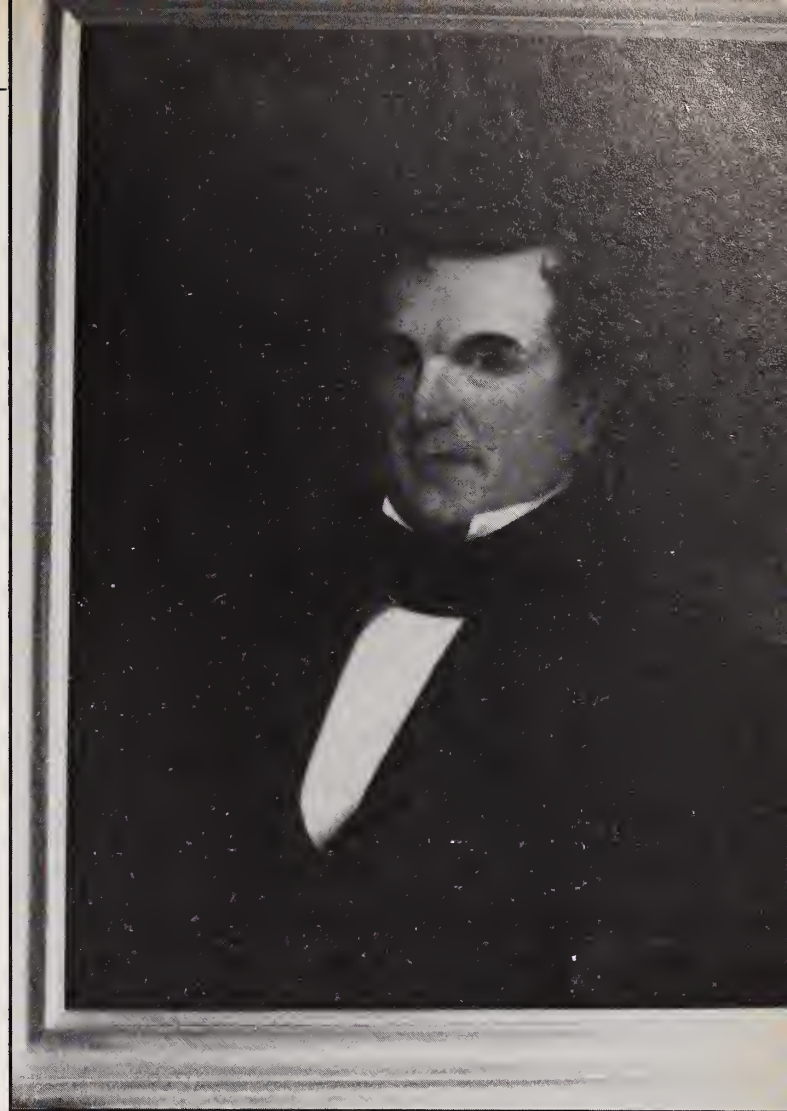
**R**ecent Presidents of the Medical College of Georgia — Edgar Pund, Harry O'Rear, William H. Moretz — are credited with much of this achievement, and in his history Dr. Spalding makes sure he recognizes as many modern-day contributors as he can. Invariably, though, the



writer of a modern institutional history hurts feelings or raises hackles at unintended or perceived errors. "You can't do this kind of history and not be controversial," the author told us, "if the history of the institution is brought up even close to the present. You are going to get involved in emphases that obviously are going to reflect the things that people who lived through the events know, or think they know. They will consider some issues more important than the ones that I, for example, might have included in my history of MCG." Spalding notes, as an aside, that he usually doesn't have these kinds of problems in his favorite field of historical research, the age of James Oglethorpe — who died over 200 years ago.

The author's final draft had to be approved by two reading committees, one composed of MCG

*DR. MILTON ANTONY of Augusta, founder of the Medical College of Georgia. In his recently published history of MCG, Prof. Spalding terms Antony "a remarkable and able man" whose "personal determination and strength of will" brought about the establishment of the Medical College. Dr. Antony died during the Augusta yellow fever epidemic of 1839 at the age of 50.*



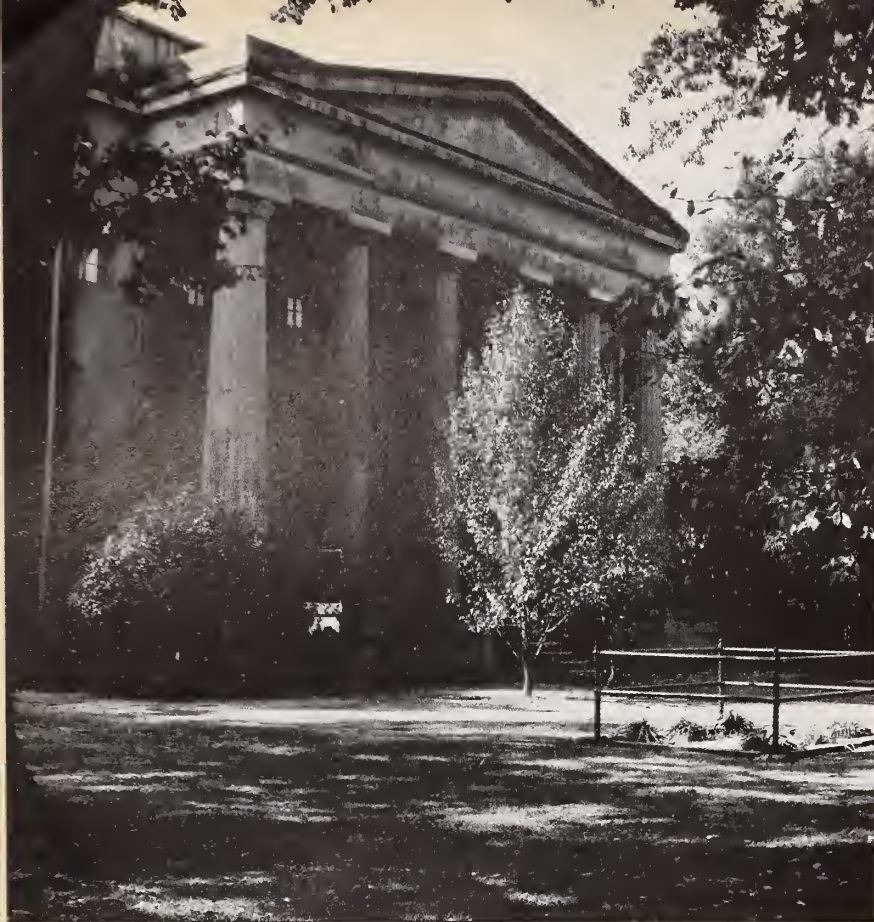
Drawn by R. Hinshelwood from a sketch by T. Addison Richards

Grahams Magazine 1844

Engraved by Rawdon, Wright, Hatch & Smillie

MEDICAL COLLEGE OF GEORGIA





THE ORIGINAL MEDICAL COLLEGE OF GEORGIA, completed in 1837. The Cluskey building, so named for principal builder Charles Cluskey, served the college until 1913. The structure, considered one of the state's finest examples of Greek Revival architecture, is the focus of an enthusiastic fundraising campaign now underway by the Medical College of Georgia Foundation. (See Dr. William C. Collins' editorial, page 84.)

administrators and staff, and one of alumni. "At the time I signed the contract," Spalding recalls, "I didn't think that this would be a problem. But the criticisms I got back from one of the committees, in relation particularly to my treatment of the history of MCG following 1950, were extensive. It took a number of years for the committee to come to the conclusion ultimately that this book was going to be published, and that it would be a good one. I think the committee made some exceedingly valid and useful points, which I generally accepted — I'd like to think with equanimity. The book is better for these strictures. But I also say that it's probably going to be a long time before I agree to write another institutional history — at least under the conditions I agreed to back in 1978."

We asked Professor Spalding about the original College building, which served MCG until 1912.

**"T**he Cluskey building [named for architect Charles Cluskey], the old Medical College, is one of the finest examples of Greek Revival architecture in the South. Now, it's in danger

from neglect. I think it is so much a part of the history of Augusta and the history of MCG, too, that I would hope that there would never be a question of its being destroyed.

"Should I add a plug? There is a strong push now by the Medical College of Georgia Foundation to raise money for the restoration of this building. More than \$600,000 has already been pledged, but the Foundation needs almost a million more to do a jam-up job. I'm convinced the loyal MCG alumni will be equal to the challenge. The building deserves no less. It is part and parcel of Augusta's and the Medical College's history. It is really one of the finest, earliest massive temple-style Greek Revival buildings in the state, along with the University chapel here in Athens. I hope that the Cluskey building holds a future with lots of good things in store."

**B**efore leaving, we asked Dr. Spalding to comment on a line he wrote in the Preface of his book: "If this volume can, through its insights and historical perspectives, help outline in some significant way the identity of the remarkable and resilient school known affectionately as MCG, then it will have served its purpose." He reemphasized it heartily:

"I'm sure that this is one of the reasons that the book was commissioned in the first place. I think through the years that the College, with its crises and triumphs, has had to ask itself several questions. What is the school's function? What is its role, not just in Georgia but regionally? Is there a role for it regionally? Or nationally? what have been MCG's contributions? And what have been the mistakes made in the past? All these questions still relate to the institution, and I think as one reads this volume with these questions in mind, that some of the answers may be found in the book. I'm not saying that they will be found explicitly, because of course when you're writing history you don't like to preach or be didactic if you can help it. But many of the issues that face the Medical College of Georgia can be looked at and implicitly understood by reading an objective treatment of MCG. I think this may be the contribution that this book makes to medical history in the state."

*Editor's note: The History of the Medical College of Georgia, by Phinizy Spalding, may be ordered directly from the University of Georgia Press, Athens 30602; or from the Medical College of Georgia Alumni House, Augusta 30912. The price is \$35. ■*



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# Confederate Medical Manuals of the Civil War

Harris D. Riley, Jr., M.D.

*Editor's Note: Journal readers may recall our feature article in January, 1986, on the administration of Confederate hospitals. Because of favorable responses to it, we were pleased to accept the following article by Dr. "Pete" Riley, authority on Civil War medicine and especially on Joseph Jones, M.D., Confederate surgeon and Augusta, Georgia, physician. Readers will note that one of the medical manuals referred to in this article was written by Dr. Henry F. Campbell of Augusta, President of the MAG 1971-72.*

**T**HE OUTBREAK of the Civil War found both the North and the South totally unprepared in medical as well as military resources. The United States Medical Department was a fossilized organization headed by Surgeon General Thomas Lawson, who was over 80 years of age and a veteran of the War of 1812. The Department had less than 100 medical officers, a handful of clinical thermometers, a gross or two of surgical kits, an inadequate transportation system, and no hospitals worthy of the name. At the outset of the war, this Department was expected to care

for an army of 16,000 soldiers. The Union Medical Department existed more in name than in fact.

The Confederate medical situation was even more desperate — a medical department had to be built from scratch. This had to be done in the face of an ever-dwindling supply of food, drugs, ambulances, and other equipment. The outlook faced by Dr. Samuel Preston Moore, the newly appointed Surgeon General of the Confederate States Army, was indeed a bleak one. In addition to lack of staff of medical officers and other personnel, the South had essentially no chemical manufacturing establishments or laboratories; the difficulty of importing drugs and medical supplies was bound to become very great should the blockade already proclaimed by the North on April 19, 1861, be successful; and the military resources of the South were

small compared to those of the North. Surgeon General Moore undertook several important steps to increase and improve the Confederate Medical Department. In addition to the recruitment of medical officers and staff and improvement of the headquarters in Richmond, examinations were prescribed to weed out incompetent personnel, and the competent were assigned to key positions. A reporting system to inform the Surgeon General's office of all pertinent medical facts and problems was instituted.

**O**ne of the most important steps he took to improve the situation was the authorization for publication of military medical manuals. Ultimately, 3,400 physicians served in the Confederate medical service. Of this number, only 26 had previous military experience. As there had been no demand for works on military surgery during the preceding half century, no new American texts had been published. Because of lack of interest, the quality of military medicine had actually deteriorated. This emergency deficiency in military medical textbooks was met in part by borrowing from the experience of European military surgeons who had

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Dr. Riley is Distinguished Professor of Pediatrics at the University of Oklahoma College of Medicine and Attending Physician at the Children's Memorial Hospital, University of Oklahoma Health Sciences Center. Send reprint requests to him at Dept. of Pediatrics, Children's Memorial Hospital, The Univ. of Okla. Health Sciences Center, P.O. Box 26901, Oklahoma City, OK 73190.



lately been engaged in warfare on the continent. This was done by both North and South. The Confederate effort, as previously mentioned, was greatly handicapped by an early and efficient blockade which prevented the entrance of an adequate number of medical texts as well as other medical supplies throughout the entire war. In fact, the blockade made Northern, British, and foreign books, medical journals, and technical works almost unobtainable.

Apparently the most widely used text on military surgery before the Civil War in this country was G. H. B. MacLeod's *Notes on the Surgery of the War in the Crimea* (1858). It was believed that the experience in the Crimean War would be most helpful. A few copies of this treatise found their way through the blockade and served as the basis for several books which were later published in the South.

In the latter part of 1861, a *Manual of Military Surgery, For the Use of Surgeons in the Confederate States Army* was prepared by J. Julian Chisolm, M.D., Professor of Surgery in the Medical College of South Carolina. The author fortunately drew from his own experi-

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***Probably the most ambitious scientific work published in the South during the Civil War was a 600-page book of medical botany written by Dr. Francis Peyre Porcher of Charleston, South Carolina, by order of the Surgeon-General. Almost every page corroborates the efficiency of the Northern blockade, for it is chiefly concerned with substitutes for unobtainable medical necessities.***

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ence, for 2 years before he had treated the wounded in Milan during the Italian War for Independence. This authoritative text was published by West and Johnston of Richmond (and was printed by Evans and Cogswell of Charleston). In the preface the author states: "In putting forth the *Manual of Military Surgery* for the use of surgeons in the Confederate

service, I have been led by the desire to mitigate, if possible, the horrors of war, as seen in its most frightful phase in military hospitals. As our entire army is made up of volunteers from every walk of life, so we find the surgical staff of the army composed of physicians without surgical experience. . . . As our country had been enjoying an uninterrupted state of peace, the collecting of large bodies of men, and retaining them in health, or the hygiene of the armies, had been a study without an object, and, therefore, without interest. When the war suddenly broke upon us, followed immediately by the blockading of our ports, all communication was cut off with Europe, which was the expected source of our surgical information. . . . No work on military surgery could be purchased in the Confederate States. As military surgery, which is one of expediency, differs so much from civil practice, the want of proper information has already made itself seriously felt." The *Manual* was reprinted in at least three editions. Considerable space was given to general health, hygiene, and food in addition to surgical methods. The title of the first



chapter is of interest: "Susceptibilities of Soldiers — Material of Armies — Recruits — Conscripts — Clothing — Cleanliness — Food — Marching — Encampments — Amusements, Etc." The third edition contains 26 plates most of which illustrated the technique of surgical procedures such as amputations. However, it dealt very little with non-surgical diseases.

Another 1861 publication prepared at the direction of the Surgeon General was *Direction for Cooking by Troops in Camp and Hospital. Prepared for the Army of Virginia, and Published by Order of the Surgeon-General, (with essays on "Taking Food" and "What Food" by Florence Nightingale)*. Richmond, Va., J. S. Randolph, 1861 (35 pp).

**I**n 1862, a Southern edition of *A Manual of Military Surgery or Hints on the Emergency of Field, Camp, and Hospital* by Samuel D. Gross was published by J. D. Randolph of Richmond. Dr. Gross was Professor of Surgery at the Jefferson Medical College of Philadelphia and his book was written primarily for Northern audiences. While the author is credited on the title page with this work, there is no record of royalties having been received from his Southern publishers.

Two editions of MacLeod's *Notes on the Surgery of the War in the Crimea* appeared in 1862. A Northern edition was published by Lippincott in Philadelphia, and a shorter abridged version was edited by Alexander N. Talley of Richmond, surgeon in the Provisional Army of the Confederate States, and president of the Army Medical Board. Dr. Talley made an appeal to retired South Carolina physicians (and likely to those in other states) to give or sell their instruments to the Army, noting that several regiments in the field

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***The year 1863 saw several important publications make their appearances, including A Manual of Military Surgery Prepared for Use of the Confederate States Army, written largely by Dr. Henry Fraser Campbell, an eminent Georgia physician, a correspondent of the Academy of Natural Sciences, a member of the faculty of the Medical College of Georgia, and one-time president of the MAG. His procedure for the reduction of inflammation in cases of "every arterial lesion liable to result from gunshot wounds" is included in this manual.***

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were not provided with these necessities. During this year, Ritchie and Dunnivant of Richmond printed an official 58-page manual containing the *Regulations for the Medical Department of the Confederate States Army*. This followed closely the form of the old United States Army regulations; the chief difference lay in the substitution of the words Confederate States wherever the term United States appeared in the original. The year 1862 also saw the publication of the official *Manual of*

*Military Surgery Prepared for the Use of the Confederate States Army, by Order of the Surgeon-General*. This illustrated text was printed on the steam presses of Ayers and Wade of Richmond, and was based in part on the experiences of European surgeons gained in the first half of the Nineteenth Century and included the Napoleonic and Crimean Wars. Two editions appeared.

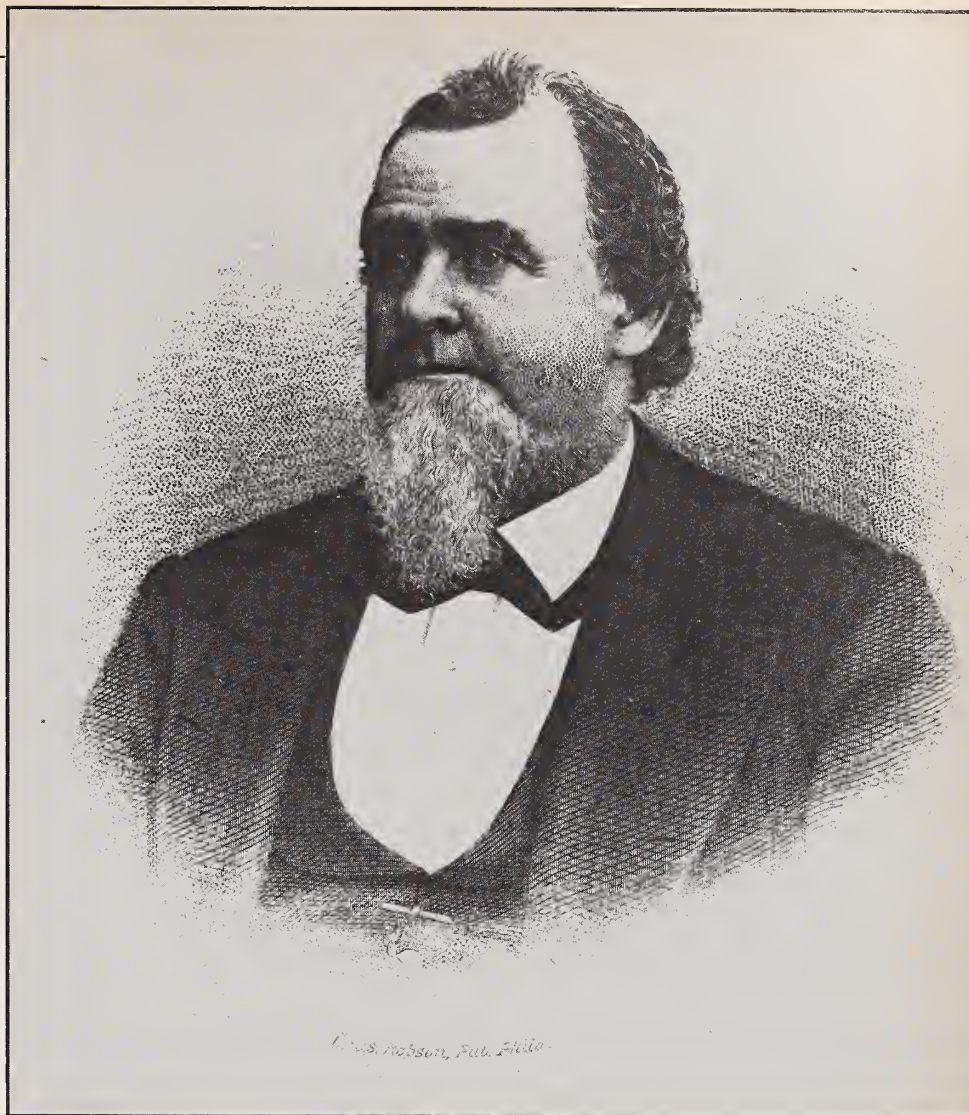
In 1863, *An Epitome of Practical Surgery for Field and Hospital* was published. It came from the versatile pen of Edward Warren, M.D., Surgeon-General of the State of North Carolina and a former professor in the University of Maryland. This 400-page text was published by West and Johnston and printed by Strother and Marcom of Raleigh, North Carolina. After the war, Warren became Surgeon-in-Chief in the Army of the Khedive of Egypt and the recipient of the French Legion of Honor, a Knighthood in the Order of Isabella the Catholic, and a Commandership of the Order of Osmanien. In the preface, Dr. Warren states that "so far as the typographical execution of this book is concerned, I must urge in extenuation of its imperfections that the best printers are in the service, and that those who remain behind are too young and inexperienced to do proper justice to any author. For this reason many errors will be found in this edition which shall be corrected in a subsequent one." As Dr. Harry Warthen of Richmond pointed out, Dr. Warren's misgivings were not without foundation for all of the copies that have been examined are designated as "Frist (sic) Editions" on the title page. Warren was responsible for several innovations to the Southern war effort including the establishment of a facility for manufacture of artificial limbs. Later, Warren pub-



lished his memoirs under the title of *A Doctor's Experience in Three Continents*, a vivid picture of an imaginative and energetic medical adventurer.

The year 1863 saw several other important publications also make their appearances. *A Manual of Military Surgery Prepared for Use of the Confederate States Army*. Richmond: Ayres and Wade, 1863 (297 pp), was an important addition. It was largely the work of Dr. Henry Fraser Campbell, who was an eminent Georgia physician, a correspondent of the Academy of Natural Sciences, a member of the faculty of the Medical College of Georgia, and one-time president of the Medical Association of Georgia. His procedure for the reduction of inflammation in cases of "every arterial lesion liable to result from gunshot wounds" is included in this manual. The monograph also gives accurate directions "by which military surgeons in the field or hospital may be guided in cutting down upon and ligating every accessible artery." It also gave excellent descriptions of certain other principles important at the time. Another 1863 imprint was *Regulations of the Medical Department of the Confederate States Army*. Richmond: Ritchie and Dunnivant, Printers, 1863 (76 pp). It provided detailed regulations for medical officers and regimental stewards as well as information on compensation, medical qualifications of officers, forms, menus, cooking directions, and supply table for hospitals.

**A**lso in 1863, probably the most ambitious scientific work published in the South during the Civil War appeared. This was entitled *Resources of the Southern Fields and Forests. Medical, Economical and Agricultural, Being Also a Medical Botany of the Con-*



HENRY F. CAMPBELL, M.D., of Augusta, Georgia, was principal author of *A Manual of Military Surgery Prepared for Use of the Confederate States Army* (1863). Dr. Campbell, a long-time faculty member of the Medical College of Georgia, served as president of both the Medical Association of Georgia (1871-72) and the American Medical Association (1884-85).

*federate States, with Practical Information on the Useful Properties of the Trees, Plants, and Shrubs*. It was printed by Evans and Cogswell of Charleston. This 600-page book of medical botany was prepared by order of the Surgeon-General and the author, Dr. Francis Peyre Porcher of Charleston, South Carolina, was relieved from duty with the Army during the 2 years required for its preparation. Porcher had graduated from the South Carolina College in 1844 and took his medical degrees from the Medical College of South Carolina in 1847. His interests in botany emerged early in his career as his medical school thesis was entitled, "A Medico-Botanical Catalogue of the Plants and Ferns of St. John's, Berkley, South

Carolina." After spending 2 years in France and Italy, Porcher returned to Charleston and assisted in establishing the Charleston Preparatory Medical School. He was subsequently elected Professor of Materia Medica in Therapeutics at the Medical College of South Carolina. His publications included contributions on yellow fever, diseases of the heart, the medical and edible properties of the cryptogamic plants, remittant fevers, and reports of 69 cases of paracentesis in patients with pleural effusion. His prize-winning essay, "Illustrations of Disease with the Microscope: Clinical Investigations," contained more than 500 original drawings. At the outbreak of the Civil War, Porcher joined the Confederate



States Army. Almost every page corroborates the efficiency of the Northern blockade, for it is chiefly concerned with substitutes for unobtainable medical necessities. Some of Porcher's suggestions are of interest: mulberry root could replace alum; blood root and wild cherry for digitalis; cotton root for ergot; wild jalap for ipecac; dandelion for calomel; hops and motherwort for laudanum; as diuretics, blackberry and dogwood leaves; knotgrass for

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***Papers in the Confederate States Medical and Surgical Journal reflect a current, basically Hunterian (after John Hunter, a famous Scots anatomist) view of inflammation as both a defensive and reparative process whereby "fibrosis precedes revascularization but, if fibrosis fails to occur, suppuration occurs by separation of pus cells from the blood."***

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diarrhea; olive oil could be replaced by peanut or cottonseed oil; belladonna by Jamestown (or Jimson) weed; and colchicum by Indian poke. As the war went on, additional substitutes were devised. Six substitutes are given for opium. These include orange-root, yellow thistle, horse-chestnuts, hops, and steeplebush. No less

than 16 substitutes are listed for coffee, which currently sold for \$2.00 a cup. Potato, asparagus, acorn, corn, sugar cane, rice, and wheat coffee are all recommended. Dr. Porcher quotes Mr. Orr of Mississippi as stating, "I find from experiments I have made that the seed of the sugar cane parched and ground as coffee, prepared in the usual way, but being boiled a little longer, makes an excellent substitute for coffee, and my own impression is that if it was brought into general use thousands would adopt its use instead of coffee, even if coffee should again be offered at its former low prices, from the fact that all could grow and cultivate it with so little labor and from its approaching so near the best Java." Later in the year a small booklet on medical botany was published: *Standard Supply Table of the Indigeneous Remedies for Field Service and the Sick in General Hospitals*. Richmond: 1863 (4 leaves).

**I**n January, 1864, the first issue of the *Confederate States Medical and Surgical Journal* appeared. This *Journal*, published by Ayres and Wade of Richmond with the approval and under the supervision of the Surgeon-General, was the official organ of the Association of the Army and Navy Surgeons which had been established in 1863. Fourteen copies of this journal were published, and the last issue appeared in February, 1865, just 6 weeks before the surrender at Appomattox. It was ably edited by Dr. James Brown McCaw of the Chimborazo Hospital in Richmond. It contained editorials, articles by Confederate medical officers on their medical and surgical experiences, and reviews of articles in foreign journals. Despite the enormous obstacles to publication, its edition reported in May, 1864, that the

*Journal* had "attained a larger circulation than was ever reached before by a Southern medical periodical and promises . . . to surpass the most sanguine expectations of its friends." The *Journal* devotes substantial attention to drug substitutes indigenous to the Confederacy. Papers in the *Journal* reflect a current, basically Hunterian [after John Hunter, a famous Scots anatomist] view of inflammation as both a defensive and reparative process whereby "fibrosis precedes revascularization [the development of blood vessels in tissue] but, if fibrosis fails to occur, suppuration [the formation of pus] occurs by separation of pus cells from the blood." This view regards post-operative infection with purulent drainage as an anticipated stage in, not a complication of, wound healing. That the *Journal* was able to continue publication as long as it did is most miraculous in view of the conditions in the war-time South at that time (1864-65). Virtually every resource of the Southern states had been utilized in support of the military effort of the Confederacy. Few copies of the *Journal* survived. In 1976, the *Journal* was reprinted and is accompanied by an excellent introduction by Wm. D. Sharpe, M.D. The reprint is a valuable addition to Civil War literature.

**T**he Medical Department of the Confederate States Army was developed from scratch and functioned in the face of tremendous odds. It had the awesome responsibility of caring for more than three million cases of disease and wounds in an invaded and blockaded country. It experienced both successes and failures. The various publications described were of great benefit to the physicians of the Medical Department in carrying out their medical missions.



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# Georgia Health Network in Perspective: 1985 to 1988 and Beyond

S. William Clark, Jr., M.D.

**A**FTER CAREFUL ANALYSIS of the group health insurance market, the capital position of the HMO, and much soul searching, the Board of Directors of the HMO voted to non-renew all existing insurance accounts as of December 31, 1987. As discussed later, this does *not* mean that the HMO is out of business, and of course the IPA continues in its representation of the membership.

The Board's decision was a difficult one to make, but was virtually dictated by the widespread underpricing in today's health insurance market. In vying for position in the Georgia marketplace over the past 18 months, the major insurance players have set their premiums at unrealistically low levels; virtually none of the insurance companies operating in Georgia, whether HMO or traditional indemnity plans, is profitable.

**T**he Board believes that group health insurance premiums will rise dramatically in the very near future and that the market will become even more unstable than it is now. We are already seeing premium increases in the 30% range for traditional carriers, and several sizable insurance com-

panies have simply left the marketplace. Because an HMO is almost invariably offered as an alternative to traditional, indemnity coverage, HMO premium-setting is a very delicate proposition, especially for a small company. If the premium is set too low, it attracts large numbers of patients, but is inadequate to cover medical costs; if it is set too high, above the indemnity rate, it attracts patients who are sick or who otherwise expect to utilize services — the phenomenon known as "adverse selection."

In these circumstances, the most prudent course for a thinly capitalized company such as ours is to minimize our exposure, protect our capital position, and re-enter the market at a more favorable time. As mentioned, this does *not* mean that the HMO is out of business. The insurance company is quite solvent — and our decision is intended to assure that we stay that way — and we will retain our insurance charter and license. In the meantime, the company continues to be courted by potential joint venture partners, and we

are not adverse to entering into such a relationship if it can be structured on terms that are favorable to our physician members.

**O**n the other side of the equation, the factors that are negative for the insurance industry underscore the positive need for GHN in its primary role as IPA. As premiums rise, there will undoubtedly be new attempts to "control costs" in ways that adversely affect patient care or that cast greater economic risks upon individual physicians. Insurers of all kinds (traditional, "managed," and self-insured employers) will attempt to impose a host of old and new kinds of controls on physicians, including capitation, discounts, and the accelerated development of PPOs or other entities based on a select "panel" of physicians.

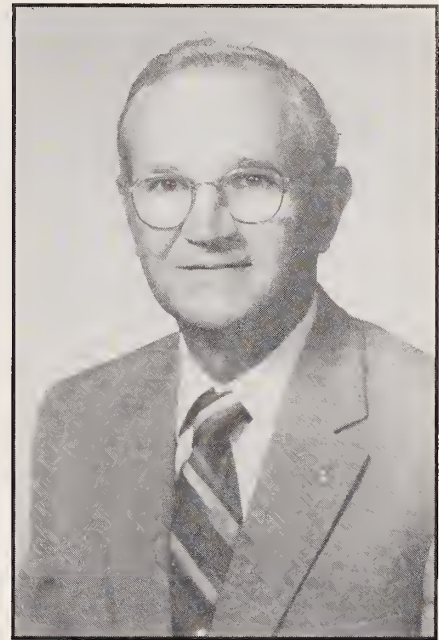
Our expectations for Georgia's medical marketplace in 1988 underscore the *compelling* need for Georgia physicians to be represented economically, and for GHN as the vehicle through which to exercise their influence. The primary mission of GHN is to negotiate on behalf of members to assure that third party plans are

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Dr. Clark is president of the Georgia Health Network.



***“In these circumstances, the most prudent course for a thinly capitalized company such as ours is to minimize our exposure, protect our capital position, and re-enter the market at a more favorable time.”***



Dr. Clark

“doctor friendly,” to the extent that is possible in today’s environment.

From an historical perspective, GHN has already produced many of the positive results that were predicted in 1985 as it moves forward to establish a role for organized medicine in medical economics. As a result of the organizational efforts of GHN: a) Georgia physicians’ understanding and level of consciousness have been raised about many of the technical aspects of managed care; b) Georgia physicians individually are better equipped to critically evaluate managed care agreements; and c) Georgia physicians are legally able to speak with a single voice on matters of common concern. Stated differently, GHN is having a fundamental and beneficial impact on the medical/economic environment in Georgia.

During 1986-87 in Georgia, we saw:

- The federal government — through CHAMPUS — dealing directly with a state physicians’ organization (GHN), and with the national consortium of physician groups that spun-off from Georgia’s program (the Alliance

of State Physician Networks). The CHAMPUS Reform Program seems to be dormant for the moment, but it will unquestionably be renewed in the future.

- Since GHN published its “Principles of Contracting,” managed care programs have faced an increasingly knowledgeable and independent group of physician prospects. When some managed care programs unilaterally moved to individual physician capitation systems they saw large numbers of individual doctors choose to discontinue their participation.
- Without a doubt, the presence of GHN in the marketplace has brought about change in the way “managed care” is managed, although it is difficult to precisely quantify those influences.

**A**s to the future, we already know what to expect in the private sector, in terms of premium increases and “cost controls.” In addition, Medicare has already committed itself publicly to the development of physician PPO’s, and CHAMPUS will unquestionably pursue its 1986 plan to put most of military health care into a “pre-paid, managed-care plan.” GHN has already demon-

strated its ability to represent Georgia physicians in negotiating with these federal government agencies in the health care arena.

Physician responses to these developing public and private economic pressures will be scrutinized *carefully* by regulatory agencies such as the Federal Trade Commission. Since 1985, the FTC has operated under a policy of viewing virtually any kind of collective economic activity by physicians as “inherently suspicious.” And the FTC will not hesitate to move at the *local level*. The FTC reviewed in considerable detail the activities of GHN during 1986-87 and found no violation of any antitrust restrictions.

Predictions beyond 1988 are speculative in this volatile field of medical economics. But into the foreseeable future, your MAG-sponsored IPA will continue to be uniquely positioned as the only statewide, physician-sponsored entity that can monitor, educate, and negotiate for its physician members across the entire spectrum of medical economic activity.

Everyone has known from the outset that the GHN venture will require hard decisions. Some phy-



sicians, doubting their own wisdom, have inquired whether they can take back their initial \$1,000 contribution, but those funds are committed to this venture in medical economics and cannot be refunded. Although every cent of the MAG "seed money" that was committed to the venture has been repaid, the individual doctors who purchased stock have not been so lucky and they should not expect a return on their investments any time soon. In such circumstances, it is important for us to remember why we are in this venture in the first place.

**“From an historical perspective, GHN has already produced many of the positive results that were predicted in 1985 as it moves forward to establish a role for organized medicine in medical economics.”**

The matter was aptly summarized by one of our own attorneys, Mr. Bill Kopit, in a recent article in *Medical Executive* magazine:

"In the face of these [many] problems why would any medical society wish to sponsor a managed health care plan? The answer is contained in one word: control. Maximizing physician control in the new world of managed care plans is clearly paramount, even when the market requires the controlled organization to choose between two or more undesirable alternatives."

We are now making those tough, undesirable decisions. But make them we must if we are to have any control over the future of our profession. The alternative is to have them made by others less friendly to us. ■

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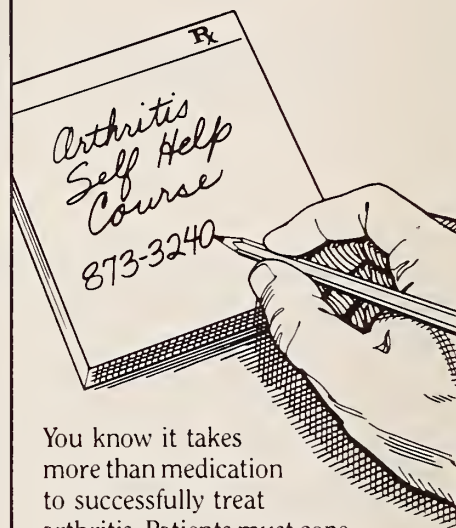
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## Hospital Liability for Staff Physician Negligence — The Line Continues to Blur

Richard H. Vincent, Robert N. Berg

**N**OT THAT long ago, there was a reasonably bright-line test to determine whether a hospital could be held liable for the negligence of a physician on its medical staff: Under the doctrine of *respondeat superior*, the hospital was held liable for damages resulting from the malpractice of a physician on the hospital medical staff only if that physician were an employee of the hospital. As stated by one Georgia Court, a "hospital owes a duty of reasonable care to its patients, and it is liable for the injuries negligently inflicted upon its patients by . . . employees of the hospital."<sup>1</sup>

Alternatively, where the physician was an independent contractor, rather than a direct employee of the hospital, it was the physician, not the hospital, who both controlled the manner and method in which he or she rendered medical services and, more importantly, who bore the responsibility for the negligent performance of those services. As

the same Georgia Court stated: "Ordinarily, a physician or surgeon on the staff of a hospital is not an employee of such hospital, and in the absence of allegations . . . that the hospital undertook to direct [the physician] in the way and manner of treating the patient, the hospital is not liable for the mere negligent performance of professional services by a physician or surgeon on its staff."<sup>2</sup>

### Historical Bases for Imposing Liability on the Hospital

Over the past decade, this bright-line test has become increasingly blurred. For example, in one case, the court made a factual determination that a physician could have been employed by the hospital, even though the hospital and physician had entered into a contract and considered the physician to be an independent contractor.<sup>3</sup> Similarly, Georgia courts adopted the theory of "independent corporate negligence" in order to find a hospital liable for allowing an unqualified or incompetent physician to practice medicine on its staff, even where the physician is an independent contractor,

rather than an employee of the hospital.<sup>4</sup>

More recently, the Supreme Court of Georgia affirmed a lower Court decision, holding that a hospital may be held liable for allowing the anesthesiologists on its staff to engage in practices which are found to be in violation of a statute, under the doctrine of "negligence *per se*."<sup>5</sup>

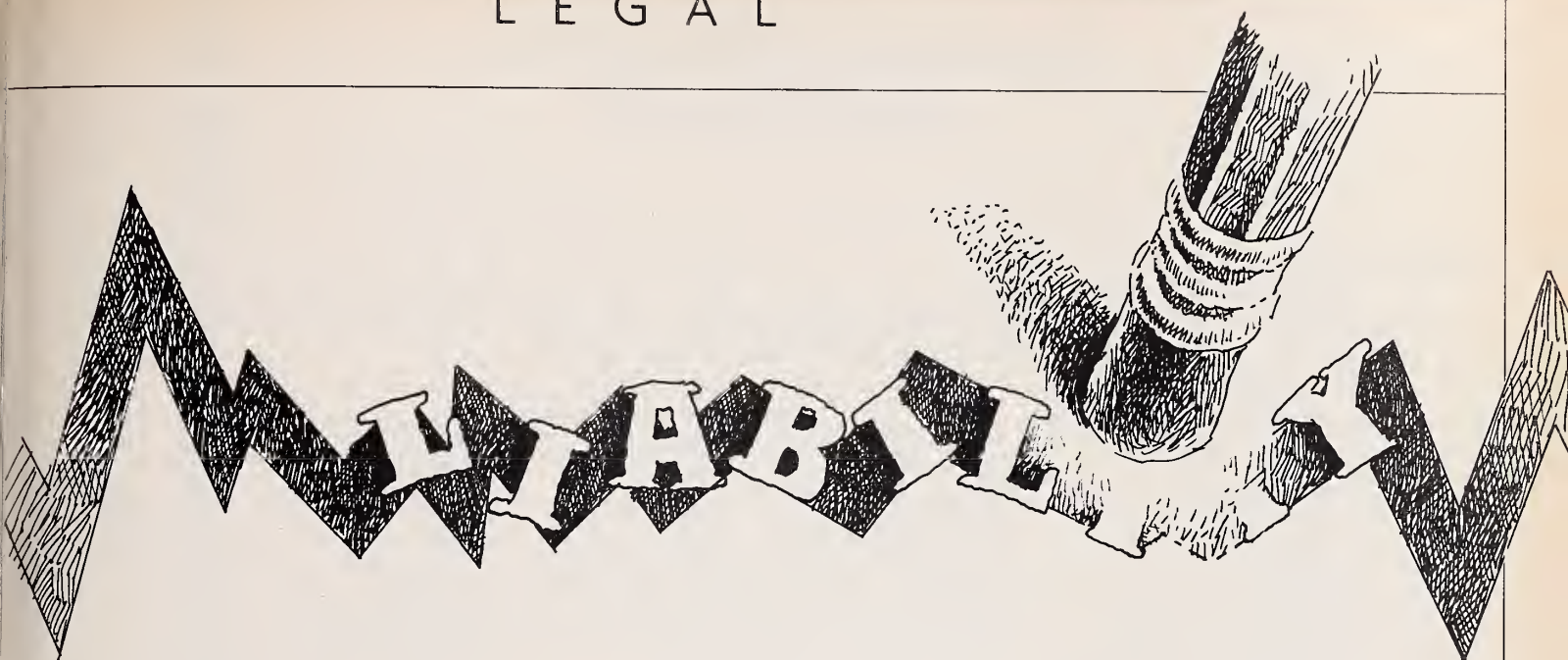
### A New Basis for Liability — "Apparent or Ostensible Agency"

A new Georgia Supreme Court case has further blurred — and indeed may have blotted out — the line used to determine hospital liability for the negligent acts of its medical staff physicians. In *Richmond County Hospital Authority v. Brown*,<sup>6</sup> Mr. Brown was injured in an automobile accident and transported to a hospital emergency room. There, he was treated by two physicians on the medical staff at the hospital where, according to the plaintiffs, he was seriously injured due to the negligent rendering of medical services by the two physicians.

In the Complaint, the plaintiffs alleged that the physicians were employees of the hospital, and, as

This article was prepared at the request of the *Journal*. Mr. Vincent and Mr. Berg are partners in the law firm of Vincent, Chorey, Taylor & Feil, Suite 1700, The Lenox Building, 3399 Peachtree Rd., Atlanta, GA 30326. Send reprint requests to Mr. Berg.





as a result, that the hospital should be liable for the physician's negligence under the doctrine of *respondeat superior*. The plaintiffs also included in the Complaint an additional count, claiming that a hospital should be liable under the doctrine of "apparent or ostensible agency" — in essence, regardless of whether the physicians *actually* were employees of the hospital, the hospital should be liable for the negligence of those physicians because the hospital represented or held the physicians out to be employees of the hospital.

The trial court granted summary judgment for the hospital, expressly finding that the physicians were independent contractors and that, accordingly, the hospital was not liable for their negligence. On appeal, the Georgia Court of Appeals upheld the trial Court's decision that the physicians were independent contractors and not employees of the hospital. However, the Court of Appeals reversed the trial court, agreeing with the plaintiffs that the hospital could have been held liable for the acts of the physicians under the doctrine of "apparent or ostensible agency."<sup>7</sup>

The Georgia Supreme Court upheld this decision by the Court of Appeals, finding that the doctrine of "apparent or ostensible agency" is a viable one in Georgia and could be used by a patient to hold a hospital liable for the negligent acts of physicians on its staff. Summarizing this doctrine, the Court stated that: "One who represents that another is his servant or other agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such."<sup>8</sup> Thus, in terms of the case at hand, the Court found that: "Most modern hospitals hold themselves out to the public as providing many health related services including services of physicians. A patient is likely to look to the hospital, not just to a particular doctor he comes into contact with through the hospital. That is what the Browns contend in this case. If they can prove the hospital represented to Isiah Brown that its emergency room physicians were its employees and that he therefore

justifiably relied on the skill of the doctors but suffered injury due to the legal insufficiency of their medical services, the hospital can be held liable therefor."<sup>9</sup>

***“From a contractual standpoint, hospitals are likely to seek indemnification from its medical staff members, for any damages incurred by the hospital as a result of the negligence of its physicians.”***

The Supreme Court did attempt to limit the scope of its holding by noting that the doctrine of "apparent or ostensible agency" seldom would be applicable to the customary situation in which a patient consults his own doctor who then has him or her admitted to a hospital where *that doctor* rendered negligent medical



**“Under the doctrine of respondeat superior, the hospital was held liable for damages resulting from the malpractice of a physician on the hospital medical staff only if that physician were an employee of the hospital.”**

services. In such a case, the Court noted, “there is no representation or holding out by the hospital to the patient. The hospital does not furnish him a doctor. He obtains his own.”<sup>10</sup> Nonetheless, the decision by the Court would appear to go a long way toward making a hospital liable for the acts of the physicians on its medical staff, regardless of whether those physicians are independent contractors or employees. Certainly, as to hospital-based physicians, such as radiologists, pathologists, anesthesiologists, and emergency room physicians, the burden will be on the hospital to prove that it did not hold itself out as offering the services of those physicians.

#### Conclusion

Only time will tell whether this is a burden that hospitals reasonably can meet. From the physician’s perspective, however, the *Brown* case may be viewed as evidencing a further change in the relationship between the hospital and the physicians on its medical staff. Structurally, hospitals should be expected to pursue documenting

the “independent” nature of its medical staff physicians — such as by posting notices advising patients of the fact that the hospital does not employ its physicians. Further, from a contractual standpoint, hospitals are likely to seek indemnification from its medical staff members, for any damages incurred by the hospital as a result of the negligence of its physicians. Whether these efforts will be successful in reducing the hospital’s potential liability, however, will not be known until Georgia courts have had an

opportunity to interpret the *Brown* case in subsequent cases.

#### Notes

1. *Newton County Hospital v. Nickolson*, 132 Ga. App. 164, 166 (1974).
2. *Id.*, at 165-166.
3. See, e.g., *Hollingsworth v. Georgia Osteopathic Hospital, Inc.*, 145 Ga. App. 870, *aff’d* 242 Ga. 522 (1978).
4. See, e.g., *Mitchell County Hospital v. Joiner*, 229 Ga. 140 (1972).
5. *Central Anesthesia Associates, P.C. v. Worthy*, 254 Ga. 728 (1985).
6. 361 S.E.2d 164 (October 21, 1987).
7. *Brown v. Coastal Emergency Services*, 181 Ga. App. 893 (1987).
8. 361 S.E.2d at 166.
9. 361 S.E.2d at 166-167.
10. 361 S.E.2d at 167.

## Myths OR Facts?

- Even moderate social drinkers may risk liver damage.
- Women are more likely to suffer liver damage from alcohol than men.
- Most victims of liver disease are *not* alcoholics.

All three statements are *true*.

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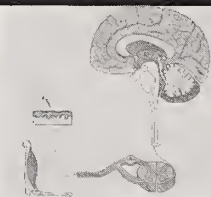
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## Monoclonal Antibodies in Imaging and Therapy

Arthur B. Kirchner, M.D., R. Roger Sankey, Ph.D.

**T**HE SEARCH for the "magic bullet" that can specifically target cancer cells and leave normal cells unaffected has led our scientific community into the world of monoclonal antibodies.

**A**ntigens are substances which are not normally present in the human body such as bacteria, viruses, or cancer cells. These antigens are recognized by the body's immune system as foreign matter. Plasma cells derived from a particular clone of B-lymphocytes in the body's immune system can produce antibodies against the antigen which then can attack and help destroy or neutralize this foreign substance. These antibodies have a variable region, Fab, which attaches to or binds the antigen and an Fc or non-specific region (Figure 1). Although antibodies on their own are unable to kill cancer cells, they become lethal at the Fc region by recruiting complement, phagocytic cells, and K<sup>-</sup> killer cells.<sup>1</sup> Several B-cell lymphocyte clones usually proliferate in response to an antigen and may produce many different antibodies, polyclonal antibodies, that recognize and attach to different parts of the

antigen. Modern technology can now produce monoclonal antibodies, MAbs, which are all identical and which recognize only one part of the antigen. Some surface structures present on cell membranes are peculiar to certain malignant cells, and they can distinguish tumor cells even from normal cells of the same tissue. MAbs can be made to these cell surface structures and tagged with radioisotopes or toxins (Figure 2).

***“The application of labeled monoclonal antibodies shows great promise for the future. Improved methods of binding the label to the antibody will be necessary.”***

These labeled antibodies can then be used to target tumor cells for imaging and therapy.<sup>2</sup> As in the use of radio-iodine for imaging and therapy for thyroid tumors, the tumor to normal tissue ratio of isotope concentration must be favorable. However, in this case, the ratio will be a complex function of the concentration of antigen present in the tumor and in normal tissue.

Antigens present in tumors have been identified in recent years and called tumor markers when found in the patient's blood stream. CEA (carcinoembryonic antigen) elevation is found in cancers of the colon, pancreas, stomach, lung, and breast. AFP (alpha feta protein) and HCG (human chorionic gonadotropin) are noteworthy in testicular tumors, whereas Ferritin is specific for liver cancer. These antigens serve as targets for radiolabeled antibodies as illustrated in Figure 2.

For practical reasons, most antibodies produced for imaging and therapy are produced from animals other than man (mouse, rabbit, sheep, cow, and monkey). This leads to one of the limitations in its repeated use. The human body can produce antibodies to the foreign animal made antibodies, destroying and rendering them useless. Thus, the use of a species-specific antigen more than once is not recommended. Multiple injections of such antibodies requires harvesting from a different animal each time. A way of overcoming this problem is to separate the Fab (specific portion) from the Fc (non-specific portion), since Fab is less immunogenic.<sup>3</sup> The ideal solution is to harvest human monoclonal antibodies; however, these are difficult to mass produce in sufficient quantity at this time.

Dr. Kirchner is Medical Director, Department of Radiation Oncology, Saint Joseph's Hospital, 5665 Peachtree Dunwoody Rd., Atlanta, GA 30342; Dr. Sankey is Physicist, Department of Radiation Oncology, Saint Joseph's Hospital, Atlanta. Send reprint requests to Dr. Kirchner.



Depending on the application, i.e. imaging or therapy, the radioisotope to be attached to the antibody should have certain physical characteristics.

**R**adioisotopes currently being investigated for imaging are listed in Table 1. For this application, the ideal nuclide should 1) have a short half-life to minimize patient exposure, 2) emit a gamma ray in the energy range 100-160 keV, 3) not emit alpha or beta particles.<sup>4,5</sup> Table 1 is a list of potentially useful imaging radioisotopes, including the advantages and disadvantages of each.

Iodine-131 has been the most common isotope used in the past for imaging. Three distinct disadvantages have led to the search for a more suitable agent: 1) the long half-life of 8 days leads to prolonged exposure of the patient to radiation, 2) the gamma energy is too high for most gamma cameras, and 3) the fact that 90% of the dose is deposited into the body by beta radiation. Indium-111 has overcome these limitations and seems to represent the best isotope for imaging to date. Some success has been achieved with Tc-99m as the label. The physical characteristics of TC-99m are ideal; however, a stable bond to the antibody is difficult to achieve.<sup>4</sup>

Factors which interfere with MAb imaging include: 1) necrotic or

large tumors which have poor vascularity, 2) normal tissues compete for the radiolabeled antibody, 3) the blood pool may contain sufficient radioactivity to mask tumors near the heart and major vessels.

**C**urrent protocols are designed to image the following tumors: colorectal, ovarian, melanoma, Hodgkins and non-Hodgkins lymphoma, and hepatoma. The protocol we have chosen to begin our research experience involves In-111 labeled MAb ZCE-025. This is an IgG2a MAb specific for a cell surface antigen on colonic cancers.<sup>6</sup> Saint Joseph's Hospital is participating with Hybritech in a phase III study of the detection of CEA producing colorectal carcinoma in patients scheduled for colorectal surgery. The study uses mouse antibody to CEA coupled to the radioactive

isotope Indium-111. Prior to surgery selected patients will be injected intravenously with a 40 milligram dose of anti-CEA monoclonal antibody, ZCE-025, labeled with 5.0 millicuries of Indium-111. The patient will be imaged in the Nuclear Medicine Department with a large field of view gamma camera fitted with a medium energy parallel hole collimator at 3 and 5 days post injection. Anterior and posterior projections will be obtained over the chest, abdomen, and pelvis. All sites of abnormal uptake will be noted by the radiologist. Nuclear scan findings will be disclosed and discussed with the oncologic surgeon prior to surgery. Surgical and pathologic findings will be correlated with the nuclear scans. Additional imaging procedures including computed tomography and magnetic resonance imaging

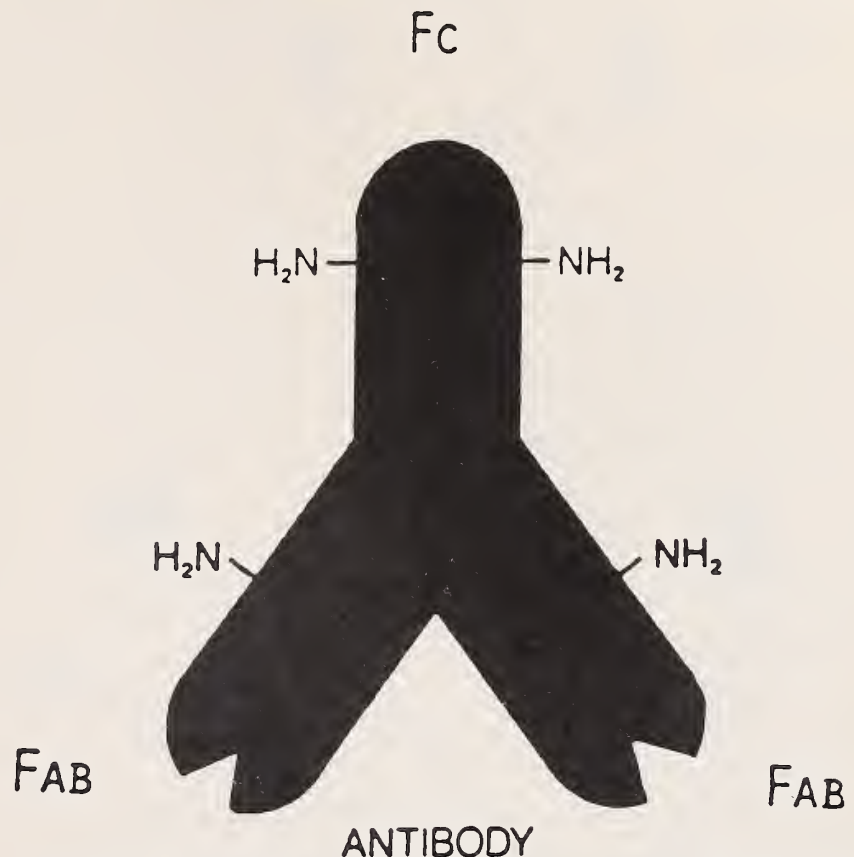


Figure 1 — A typical antibody molecule has two antigen binding sites, Fab, and an Fc region.



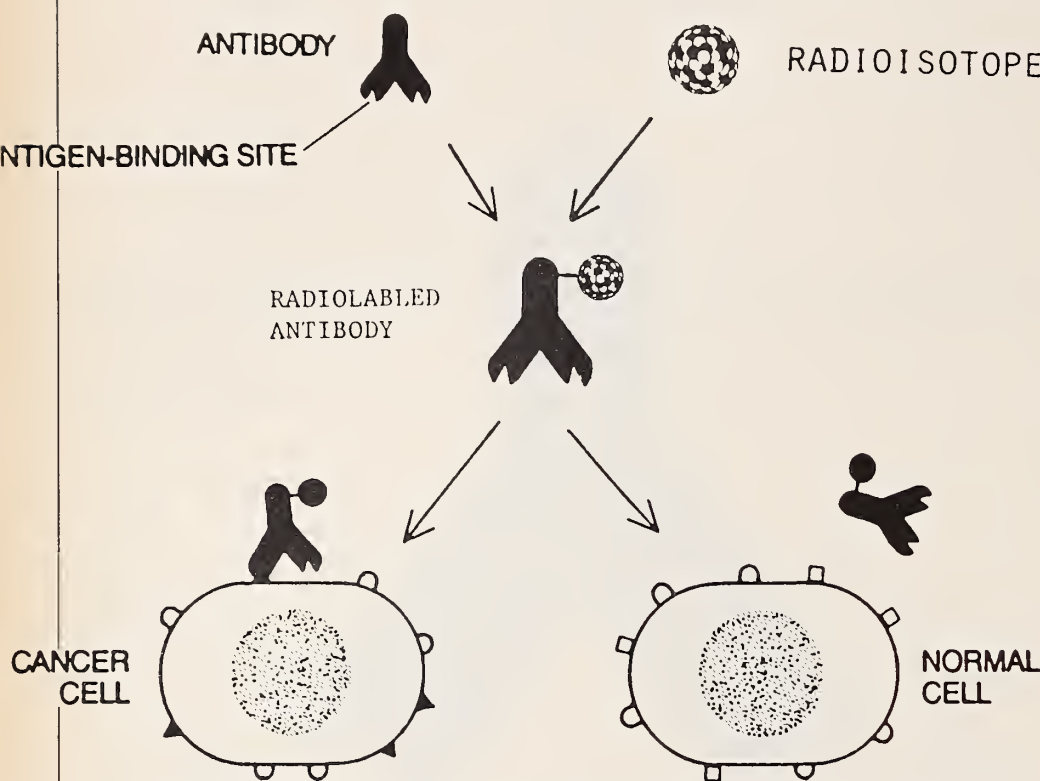


Figure 2 — Radiolabeled antibodies can bind to cancer cells while ignoring normal cells.

TABLE 1 — Radioisotopes Being Investigated for Imaging

Isotope	Advantages	Disadvantages
Iodine-131	Easy to attach; Does not alter function of the antibody	Long half-life; Gamma energy; Disassociation in vivo
Iodine-123	Same as I-131; Ideal gamma energy	Short half-life; Disassociation
Indium-111	Favorable half-life and Gamma energy	Stability of bond in vivo
Technetium 99m	Ideal gamma energy	Short half-life; Unstable bond

will be performed in patients who have localization of labeled antibody in areas not known to contain tumor and which are located outside of the surgical field. A blinded panel of radiologists will read and interpret CT and other diagnostic images versus the monoclonal scans at Hybritech during and after completion of the study. The purpose of this study is to determine the usefulness of the labeled MAb scan with other non-invasive tests.

The person credited with popularizing the concept of using radioactive antibodies in cancer therapy is Dr. Stanley Order. He has taken a hepatoma tumor model which is relatively resistant to conventional therapy (22% PR rate using 5FU and Doxorubicin combined with external radiation). Using I-131 labeled antiferitin he has achieved a 50% response rate (7% [CR] and 43% PR) with many long term remissions.<sup>7,8</sup>

Table 2 summarizes the advantages and disadvantages of

isotopes currently being considered for radiotherapeutic applications. The selective tumor uptake of radiolabeled antibody must be sufficient to deliver the desired dose, and the half-life must not be so long as to be a hazard to normal tissues. Pure alpha and beta emitters are ideal, since they concentrate the absorbed dose in the tumor volume. Since most patients have both large and small metastases, treatment may require the use of MABs labeled with two different isotopes. The large necrotic tumor requires an isotope with a longer radiation path length than do small metastatic tumor deposits. In fact, each patient will require careful study to determine which agent(s) are best with respect to concentration, antigenic targets, and normal tissue concentration. As in imaging, most therapy to date has employed Iodine-131. Iodine-131 is clearly not ideal since the physical half-life of Iodine is long (8 days) and the gamma energy is high (364 keV). A more promising isotope currently under investigation is Yttrium-90 with a half-life of 2.7 days and an average beta energy of 0.935 MeV. Being a metal it may be chelated to antibodies, a more stable bond than halogenation. Other isotopes which may be effective include Bismuth-212, Lead-212, and Bromine-77.

## Immunotoxins

Finally, the use of monoclonal antibodies to deliver toxic agents to cancer cells also shows great promise.<sup>9</sup> A good example of such an agent is the diphtheria toxin (see Figure 3). This molecule is divided into two active chains. The b chain binds to a receptor on the cell surface and the toxin is carried to a "coated pit" on the cell surface where the plasma membrane invaginates and pinches off to form a vesicle called an endosome. The B chain inserts itself into the endosomal membrane and the A chain crosses the membrane and is released into



the cytoplasm where it causes the transfer of ADP ribose to EF-2 resulting in cell death. Since the diphtheria toxin is non-discriminatory it can attach to any cell in the body. By substituting a monoclonal antibody directed against a tumor associated antigen for the B chain, one can make this toxin tumor specific. Monoclonal antibodies are not as efficient in releasing the A chain into the cytoplasm as the B chain; therefore it is not lethal enough for clinical use as yet. It is hoped that genetic engineering of these molecules will be the key to the future of immunotoxins as antineoplastic agents.<sup>9</sup>

The application of labeled (isotope, chemical, toxin) monoclonal antibodies shows great promise for the future. Improved methods of binding the label to the antibody will be necessary for the continued development of this method. Equally important is the need to develop labeled antibody systems which have a better tumor to normal tissue target ratio in order to reduce non-specific localization in organs such as the liver. Research directed at solving these problems continues and it is anticipated that imaging and treatment with labeled MABs will play an important role in cancer treatment.

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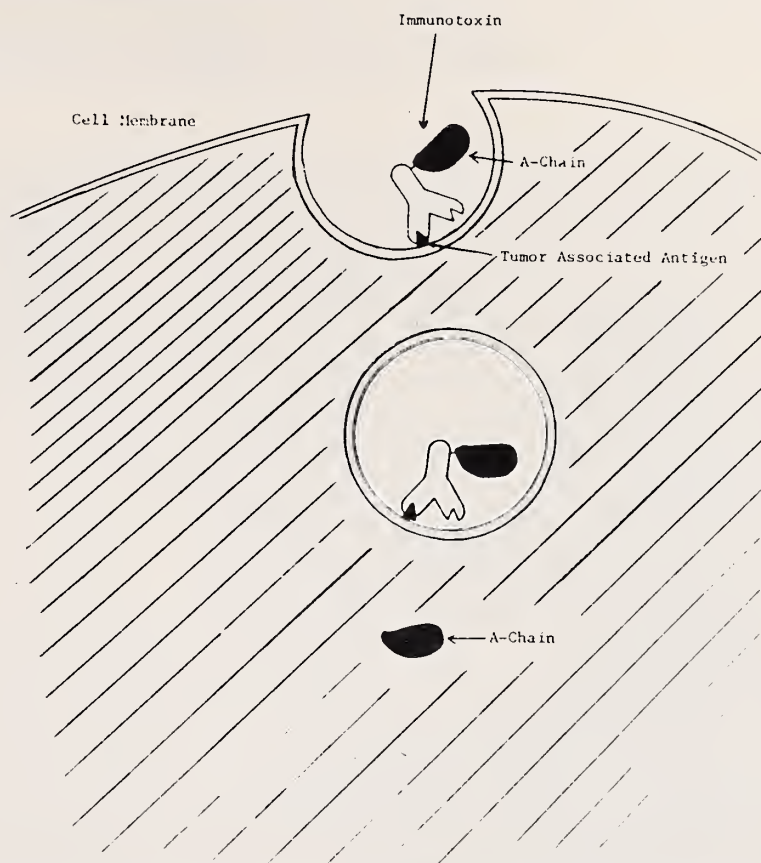


Figure 3 — A diphtheria toxin labeled antibody is incorporated by a tumor cell. The released A-chain destroys the cell.

TABLE 2 — Potential Therapeutic Agents

Isotope	Advantages	Disadvantages
Iodine-125	Auger electron emitter, low energy x-rays, available, Single cell kill	Range too short for large necrotic tumors
Iodine-131	Beta emitter, available	Dehalogenation in vivo, 364 keV gamma emission
Yttrium-90	Beta emitter, available	
Bromine-77	Auger electron emitter, available, Single cell kill	Range too short for large tumors
Bismuth-212	Alpha, high energy, Short range	Short half-life, difficult to conjugate
Toxins	High potency	Must enter cell to work, difficult to conjugate

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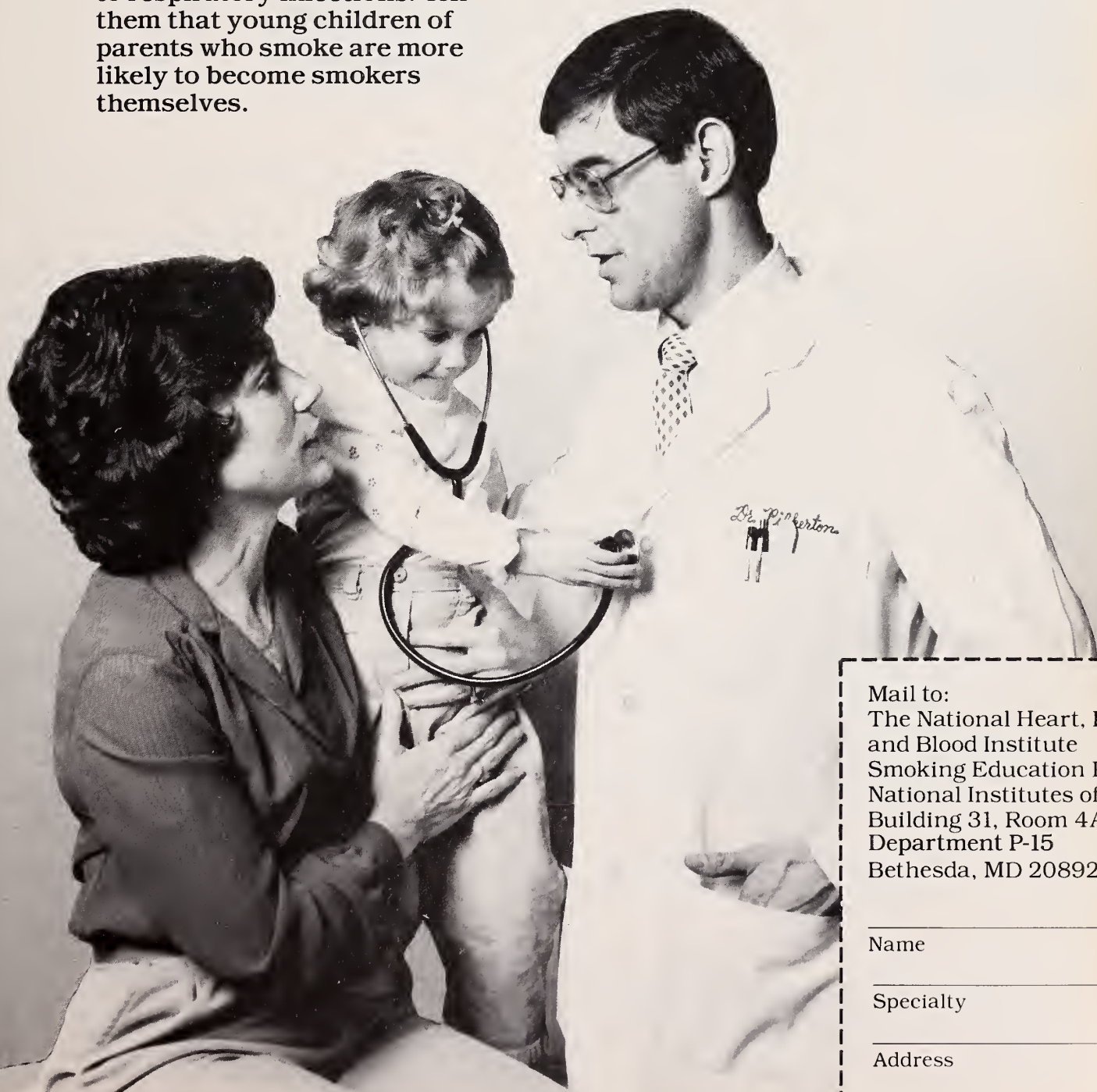
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#### WARNINGS

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Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

#### Gastrointestinal Lesions

Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

#### Metabolic Acidosis

Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

#### PRECAUTIONS

##### General:

The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

##### Information for Patients

Physicians should consider reminding the patient of the following:

To take each dose without crushing, chewing, or sucking the tablets.

To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.

To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.

To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

##### Laboratory Tests

Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

##### Drug Interactions

Potassium-sparing diuretics: see WARNINGS.

##### Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in animals have not been performed.

##### Pregnancy Category C

Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

##### Nursing Mothers

The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

#### Pediatric Use

Safety and effectiveness in children have not been established.

#### ADVERSE REACTIONS

One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

#### OVERDOSAGE

The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 mEq of 10% dextrose solution containing 10-20 units of insulin per 1,000 mL; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

#### DOSAGE AND ADMINISTRATION

The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

**Note:** Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

#### HOW SUPPLIED

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Before prescribing, please consult Brief Prescribing Information on next page.



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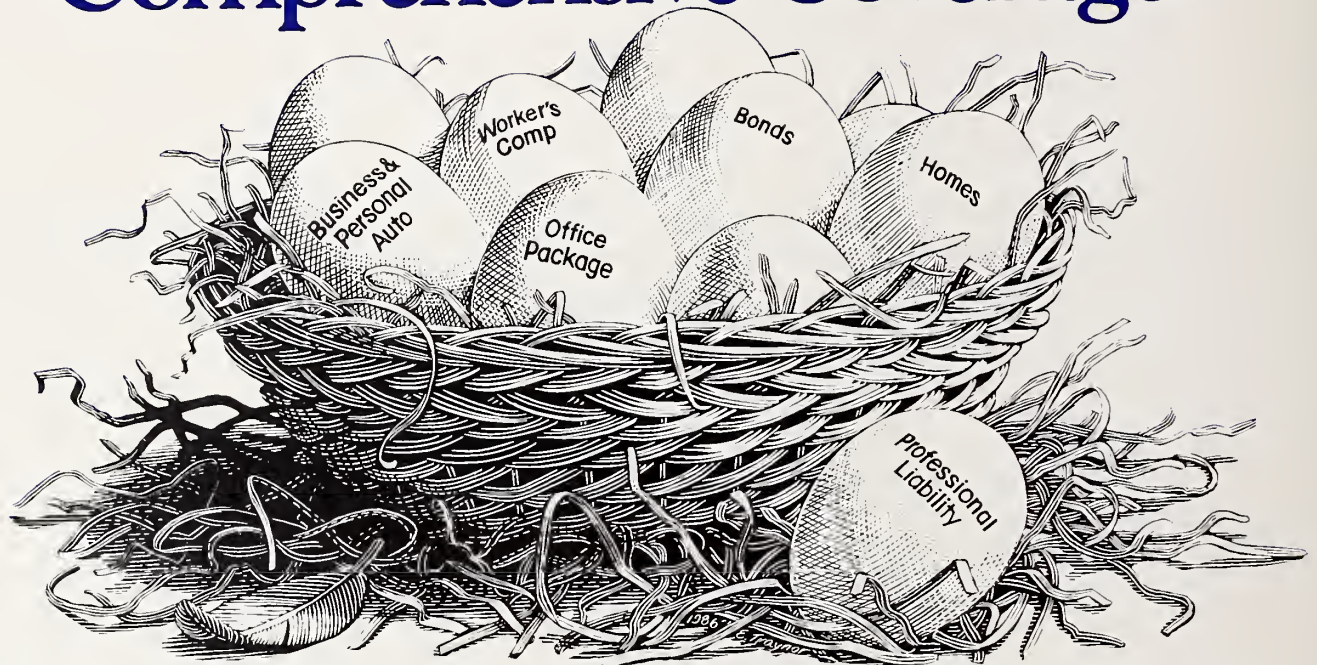
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**Precautions:** While a weak antiandrogenic effect has been demonstrated in animals, 'Tagamet' has been shown to have no effect on spermatogenesis, sperm count, motility, morphology or in vitro fertilizing capacity in humans.

In a 24-month toxicity study in rats at dose levels approximately 9 to 56 times the recommended human dose, benign Leydig cell tumors were seen. These were common in both the treated and control groups, and the incidence became significantly higher only in the aged rats receiving 'Tagamet'.

Rare instances of cardiac arrhythmias and hypotension have been reported following the rapid administration of 'Tagamet' HCl (brand of cimetidine hydrochloride) injection by intravenous bolus.

Symptomatic response to 'Tagamet' therapy does not preclude the presence of a gastric malignancy. There have been rare reports of transient healing of gastric ulcers despite subsequently documented malignancy.

Reversible confusional states have been reported on occasion, predominantly in severely ill patients.

'Tagamet' has been reported to reduce the hepatic metabolism of warfarin-type anticoagulants, phenytoin, propranolol, chlordiazepoxide, diazepam, lidocaine, theophylline and metronidazole. Clinically significant effects have been reported with the warfarin anticoagulants; therefore, close monitoring of prothrombin time is recommended, and adjustment of the anticoagulant dose may be necessary when 'Tagamet' is administered concomitantly. Interaction with phenytoin, lidocaine and theophylline has also been reported to produce adverse clinical effects.

However, a crossover study in healthy subjects receiving either 'Tagamet' 300 mg. q.i.d. or 800 mg. h.s. concomitantly with a 300 mg. b.i.d. dosage of theophylline (Theo-Dur®, Key Pharmaceuticals, Inc.),

demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg. h.s. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. [Note: All patients receiving theophylline should be monitored appropriately, regardless of concomitant drug therapy.]

Lack of experience to date precludes recommending 'Tagamet' for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks; generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

**Adverse Reactions:** Diarrhea, dizziness, somnolence, headache, rash. Reversible arthralgia, myalgia and exacerbation of joint symptoms in patients with preexisting arthritis have been reported. Reversible confusional states [e.g., mental confusion, agitation, psychosis, depression, anxiety, hallucinations, disorientation], predominantly in severely ill patients, have been reported. Gynecomastia and reversible impotence in patients with pathological hypersecretory disorders receiving 'Tagamet', particularly in high doses, for at least 12 months, have been reported. Reversible alopecia has been reported very rarely. Decreased white blood cell counts in 'Tagamet'-treated patients (approximately 1 per 100,000 patients), including agranulocytosis (approximately 3 per million patients), have been reported, including a few reports of recurrence on rechallenge. Most of these reports were in patients who had serious concomitant illnesses and received drugs and/or treatment known to produce neutropenia. Thrombocytopenia (approximately 3 per million patients) and a few cases of aplastic anemia have also been reported. Increased serum transaminase and creatinine, as well as rare cases of fever, interstitial nephritis, urinary retention, pancreatitis and allergic reactions, including hypersensitivity vasculitis, have been reported. Reversible adverse hepatic effects, cholestatic or mixed cholestatic-hepatocellular in nature, have been reported rarely. Because of the predominance of cholestatic features, severe parenchymal injury is considered highly unlikely.

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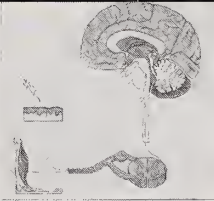
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**COVER**

The isolation of personal suffering is communicated both beautifully and poignantly in the painting by Atlanta artist, Margo Owens, on this month's cover. We thought it fitting, therefore, to use this art to represent the suffering and isolation experienced by persons with AIDS — a disease which not only kills but also emotionally traumatizes and isolates those whom it afflicts because of the fear and prejudice associated with its transmission.

We gratefully acknowledge the cooperation of the owners of this painting, Tony Ardavin and Michael Tilson of Kennesaw, in allowing us to photograph it for use on this cover.

Cover photo by Chuck Rogers, of Rogers and Bigit, Atlanta.



## Georgia Hospitals Outline National Concerns

**R**EPRESENTATIVES from Georgia's hospitals met early this month with the state's congressional delegation in Washington, DC, to present the issues facing today's hospitals and to recommend solutions. Topics for discussion included the following:

- Medicare: increase the 1989 Medicare rates to match the increase in the hospital marketbasket.

- Medicaid: eliminate limits on Medicaid rates that tie state increases to the increase in Medicare DRG payments.

- Rural hospitals: for rural hospitals that treat large numbers of Medicare and indigent patients, provide payment adjustments equal to those given to urban hospitals.

- Employee health insurance: require employers to provide a certain amount of health insurance, create state risk pools for the medically uninsurable, and provide tax benefits for self-employed persons who purchase health insurance.

- Nursing: increase funding for public health services and fund studies of nurse retention and new ways to deliver nursing care.

- Peer review organization: withhold further publication of Medicare mortality data until other measures of quality can be identified; allow for

a review of PRO decisions before sanctions can be imposed; and require PROs to increase review of hospitals that have utilization and quality problems but decrease review of hospitals having no such problems.

- AIDS: provide funding for research, education, inpatient care, and alternatives to hospitalization.

## Nurses' Salaries See Increase

**H**OSPITAL STAFF NURSES saw an average 4.6% salary increase last year, reports the *American Journal of Nursing*.

The average base salary in 1987 was \$21,126 — up from \$20,186 the year before. The average top salary last year was \$29,350 — up from 1987's average of \$27,404.

But those numbers can be deceiving, because salaries vary extremely according to geography. Starting salaries ranged from a low of \$15,537 in Washington, DC, to a high of \$34,819 in San Francisco.

## Hospitals' Medicare Profits on the Downswing

**H**OSPITAL PROFITS from Medicare payments dropped nearly 40% from 1985 to 1986, reports the Health Care Financing Administration (HCFA). During the first 2 years of

prospective payment, hospitals were seeing about 15% profit, but by 1986 that amount had dropped to 9.4%. In addition, the number of hospitals that actually saw a profit from Medicare income fell from 78% in 1985 to 63% in 1986.

The dwindling profit, says the government, is due to greater operating costs as well as smaller DRG payment updates. Says one government official, HCFA now wants to know if hospitals really are having a tough time of it or if their high operating costs are "due to a reallocation of costs . . . in an effort to show declining patient margins."

## Health Insurance Premiums See 15% to 35% Hike

**W**HOTO'S TO BLAME for this year's big hikes in insurance premiums? Health care inflation, says the insurance industry. But the health care industry says last year's medical costs climbed to nowhere near the 15% to 35% increase in insurance costs.

Regardless of the cause, the cost of health insurance is going up. Aetna Life and Casualty Company has raised its premiums an average of 30%, and Blue Cross estimates a 15% to 25% increase in its premiums this year. Average premium increases for HMOs are ranging from 5% to 15%. ■



# CALENDAR

## APRIL

6-8 — *Atlanta: The Emory Symposium on Effective Utilization of Magnetic Resonance.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

7-9 — *Atlanta: New Trends in Colposcopy.* Category 1 credit and ACOG Formal Learning Cognates. Contact Institute for Cancer Control, Northside Hospital, 1000 Johnson Ferry Rd., Atlanta 30342. 404/851-6100.

14-17 — *Atlanta: American College of Preventive Medicine Annual Meeting.* ACPM, 1015 15th St., NW, Suite 403, Washington, D.C. 20005. PH: 202/789-0003.

15-16 — *Atlanta: Georgia Chapter, American College of Surgeons Spring Meeting.* Contact Ellis B. Keener, M.D., Secy., 434 Academy St., Gainesville 30501. PH: 404/532-6333.

18-22 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

20-22 — *Atlanta: The Annual Renal Rehabilitation Issues in Dialysis and Transportation.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

22-23 — *Atlanta: Georgia Chapter, Baptist Medical — Dental Fellowship Annual Meeting.* Contact Teresa Clark, M.D., 490 Peachtree St., Atlanta 30308. PH: 404/688-8960.

22-24 — *Augusta: The Specter of AIDS — a practical conference for health professionals.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

23-27 — *Sea Island: Masters in Gynecology and Obstetrics.* AMA Category 1 and ACOG cognate credits. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

28-29 — *Atlanta: Pharmacology for the Anesthesiologist.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

30-May 1 — *Atlanta: The Cardiac Patient.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

## MAY

1-4 — *Sea Island: Georgia Society of Ophthalmology.* Category 1 credit. Contact Ray M. Williams, GSO, 938 Peachtree St., Atlanta 30309. PH: 404/876-7535 or 800/282-0224.

2-6 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

2-7 — *Augusta: Primary Care and Family Practice Symposium.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

4-6 — *Atlanta: Selected Procedures for the Management of Disorders of the Adult Foot and Ankle.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

5-6 — *Atlanta: Psychosocial and Family Issues Following Traumatic Brain Injury.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

5-7 — *Hilton Head Island, SC: Cementless Hip Replacement.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

5-8 — *Destin, FL: Anesthesia for the Transplant Patient.* Amer. Acad. of Anesthesiologists' Assistants Annual Meeting; Cosponsored by Ga. Socy. of Anesthesiologists. Category 1 credit. Contact AAAA, P.O. Box 77253, Atlanta 30357. PH: 404/727-5910.

12-15 — *Savannah: Georgia Radiological Society.* Category 1 credit. Contact James M. Moffett, 938 Peachtree St., Atlanta 30309. PH: 404/876-7535 or 800/282-0224.

14-15 — *Augusta: Pathology Symposium.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

20-21 — *Unicoi State Park: Georgia Rheumatism Society Annual Meeting.* Category 1 credit. Contact Richard S. Field, M.D., 3126 Exeter Rd., Augusta 30909. PH: 404/733-7848.

23-26 — *Atlanta: Science and Medicine.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

23-27 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

28-29 — *Sea Island: Georgia Neurosurgical Society.* Category 1 credit. Contact Herman Flanigin, M.D., Secy-Treas., MCG, Augusta 30912. PH: 404/828-3071.



## *MAG Involved in the Fight Against AIDS*



*Jack F. Menendez, M.D.*

**I**N THE 7 YEARS since the first cases of AIDS were identified, we have seen the number of cases increase to about 42,000, with about 30,000 deaths so far. These numbers qualify AIDS as an epidemic, the consequences of which are being addressed by medical science.

The Medical Association of Georgia has been involved in the fight against AIDS in many ways. For example, this is the third issue of the *MAG Journal* devoted to AIDS since 1984. The MAG AIDS Task Force recently issued a comprehensive report on AIDS which includes information on testing, demographics, confidentiality, and much more (published in the January, 1988, *Journal*). We have initiated an education program for both the public and physicians throughout Georgia, including a highly successful packet of AIDS information.

These activities, along with working with our State Legislature to shape the best AIDS policy bill, have put MAG squarely in the forefront of the ongoing battle against this dread disease. This issue of the *Journal* has some of the latest information on the status of AIDS in Georgia. I hope you find it informative and useful.

*Jack F. Menendez*



## NEW MEMBERS

Cancel, Angel R., Pediatrics/  
Anesthesiology — Bibb — 777  
Hemlock St., Macon, 31208

Cockerill, James W., Psychiatry —  
Richmond — 458 Highlands Ct.,  
Martinez, 30907

Cooney, Michael, Orthopaedic  
Surgery — Bibb — 671 Hemlock  
St., Macon, 31201

Darville, Wayne N., Pediatrics —  
MAA — 6153 Old National  
Highway, P.O. Box 491145,  
College Pk., 30349

Davidson, P. Carl, Ophthalmology  
— Floyd-Polk-Chattooga — 1825  
Martha Berry Blvd., Rome, 30161

Dopson, Thomas L., Orthopaedics  
— MAA — 315 Blvd. N.E. Ste.  
312, Atlanta, 30312

Dudley, Carolyn G., Diagnostic  
Radiology — Muscogee — 4000  
Pickering Dr., Columbus, 31907

Goolsby, Kenneth E., Jr., Child,  
Adolescent & Adult Psychiatry —  
Hall — 304 South Enota Dr.,  
Gainesville, 30501

Gunther, John S., Gastroenterology  
— Richmond — 1217 West  
Medical Pk. Rd., Augusta, 30909

Hedaya, Ellis V., Neurology — MAA  
— 25 Prescott St., Atlanta 30365

Helton, Timothy, Family Practice —  
MAA — 1121 Johnson Ferry Rd.,  
Ste. 300, Marietta 30068

Holmes, Gregory L., Pediatric  
Neurology — Richmond — VA  
Medical Center, Augusta 30910

Hubert, Robert A., Internal Med. —  
MAA — 490 Peachtree St., Ste.  
242-B, Atlanta 30308

Huntley, William W., Neurology —  
Troup — 2028 N.W. 36th Dr.,  
Gainesville, FL 32605

Jackson, Edgar N., Obstetrics/  
Gynecology — MAA — 21 Eighth  
St., N.E., Atlanta 30309

Jagiella, Valerie J.,  
Gastroenterology — Richmond  
— 3924 Old Trail Rd., Augusta  
30907

Jamshidi, Khossrow,  
Otolaryngology — Clayton-  
Fayette — Ste. 120, 33 S.W.  
Upper Riverdale Rd., Riverdale  
30274

Johnson, David E., Pediatrics —  
Dougherty — 1712 East Broad  
Ave., Albany 31705

Jones, Mark M., Plastic Surgery —  
MAA — 424 Webster St., Palo  
Alto, CA 94301

Kent, David E., Dermatology —  
Bibb — 330 Hospital Dr., Ste.  
208, Macon 31213

Kim, Joon Han, General Surgery —  
Bibb — 800 First St., Ste. 310,  
Macon 31207

King, John W., Internal Med./  
Pulmonary Diseases — Baldwin  
— 811 North Cobb St.,  
Milledgeville 31061

Kuchler, Linton L., Pathology —  
Hall — Dept. of Pathology,  
Northeast Georgia Med. Center,  
Gainesville 30505

Lacey, Dennis M., Neurology —  
MAA — 1277 Franklin Cir.,  
Atlanta 30324

Mayweather, William H.,  
Anesthesiology — Muscogee —  
The Medical Center, P.O. Box

2748, Columbus 31902

McClees, Eric C., Radiology —  
MAA — 1984 Peachtree Rd., Ste.  
505, Atlanta 30309

Morris, Elsie C., Allergy &  
Immunology — MAA — 4020  
Emma Lane, N.E., Atlanta 30342

Porter, Cedric E., Family Practice  
— Emanuel — Rt. 4, Box 321-A,  
Swainsboro 30401

Powell, Anita H., Pediatrics —  
Spalding — 670 South Eighth St.  
Griffin 30223

Prather, Stuart H., III, Diagnostic  
Radiology — Richmond —  
Medical College of Georgia,  
Augusta 30912

Rabon, Sherrill L., Neurology —  
Richmond — 3323 Quaker  
Spring Rd., Augusta 30907

Rampell, Nancy, Neurology — MAA  
— 3758 Vermont Rd., N.E.,  
Atlanta 30319

Roman, Stanford A., Jr., Internal  
Med. — MAA — 720 Westview  
Drive, S.W. Atlanta 30310-1495

Sacks, Linda, Neurology —  
Richmond — 3323 Quaker  
Springs Rd., Augusta 30907

Savory, Carlton G., Orthopaedic  
Surgery — Muscogee — 6262  
Hamilton Rd., Columbus 31995

Schwartz, Meyer P., Family Practice  
— Richmond — 2326-B Spring  
House Lane, Martinez 30907

Silk, Howard J., Allergy &  
Immunology — MAA — 6667  
Vernon Woods Dr., A-30, Atlanta  
30328



Smith, David G., Internal Med. —  
Georgia Medical — 11700 Mercy  
Blvd., 5 St. Josephs Med. Office  
Pk., Savannah 31499

Smith, Robert W., Family Practice  
— Bibb — 784 Spring St., Macon  
31201

Spriick, Gary L. — Bibb — 777  
Hemlock St., Macon 31208

Straub, Robert F., Internal Med. —  
MAA — 3085 Colonial Way,  
Chamblee 30341

Tice, Andrew W., Otolaryngology  
— Bibb — 330 Hospital Dr., Ste.  
212, Macon 31213

Trotter, Lanny F., Obstetrics/  
Gynecology — Colquitt — 315-  
15th St., S.E., Moultrie 31768

Van, David A., Family Practice —  
Spalding — 107 Graefe St.,  
Griffin 30223

Walburn, Jonathan R., Pathology —  
Muscogee — Columbus  
Pathology, P.C., P.O. Box 4176,  
Columbus 31995

Webster, Bruce S., Emergency Med.  
— Bibb — 1658 Coleman Ave.,  
Macon 31201

Wood, Charles O., Neurosurgery —  
Gwinnett-Forsyth — 100 Medical  
Center Blvd., Ste. 255,  
Lawrenceville 30245-4305

Workman, Dennis C., Psychiatry —  
MAA — 2150 Peachford Rd., Ste.  
A, Atlanta 30338

Zahn, Priscilla E., Internal Med. —  
MAA — 4885 Franklin Pond,  
Atlanta 30342

## QUOTES

*Failure to accord credit to anyone  
for what he may have done is a  
great weakness in any man.*

WILLIAM HOWARD TAFT

*Misfortunes are like knives, that  
either serve us or cut us, as we  
grasp them, by the blade or by the  
handle.*

JAMES RUSSELL LOWELL

*No one is useless in this world  
who lightens the burden of it to  
anyone else.*

CHARLES DICKENS

*A wise man will make tools of  
what comes to hand.*

THOMAS FULLER

*Victories that are easy are cheap.  
Those only are worth having which  
come as the result of hard fighting.*

HENRY WARD BEECHER

*The recipe for perpetual ignorance  
is: Be satisfied with your opinions  
and content with your knowledge.*

ELBERT HUBBARD

*The worst handicap is to be  
unloved, the second worst  
handicap is to be unloving.*

FRANK TYGER

*Many persons might have attained  
to wisdom had they not assumed  
they already possessed it.*

SENECA

*A real friend is one who walks in  
when the rest of the world walks  
out.*

WALTER WINCHELL

## Hemophilia Hotline

**1-800-562-1800, Ext. 062**

**F**or the first time in the history of the treatment of hemophilia in Georgia, there is a 24-hour statewide physician-to-physician consultation phone service. The service has been in effect for about one year and is the combination of efforts by Hemophilia of Georgia and six physicians in Atlanta and Augusta who have a special interest in this congenital and lifelong coagulopathy.

The need for access to emergency consultation has been expressed by both physicians and patients throughout Georgia. Most of the time patients with Hemophilia or others with bleeding problems are able to compensate and live normal and full lives. However, if an emergency or accident arises it is often not the patient's own physician who is faced with providing the treatment.

Hemophilia is not common. There are only approximately 500 patients in Georgia, and several more are added to our population as they travel through or visit from out of town. The service has been designed to assist physicians in the management of patients with hemophilia. It is hoped that the hotline will provide useful and possibly lifesaving information.

*(Reported by Beverly A. Bell,  
M.D., general practitioner, Atlanta.)*



## TRIBUTE TO DR. HERMAN DELANCY

On November 25, 1987, our medical community, the people of Savannah, and the surrounding area lost a wonderful friend and capable colleague, Dr. Herman Delancy. His career in Savannah spanned a period of 31 years. He was born in Cartersville, Georgia, February 14, 1923. There, he spent his formative years and graduated from Cartersville High School.

Dr. Delancy did his undergraduate studies at Vanderbilt University and received his M.D. degree in 1946 from the Medical College of Georgia. He was an Honoree of the Alpha Omega Alpha honor fraternity in his junior year. He served his internship at the University Hospital in Augusta, Georgia, July 1946 through June 1947. Subsequently, he served in the Medical Corps Surgical Service in the U.S. Army stationed at Oliver General Hospital in Augusta, Georgia, from November 1947 to September 1949. It was there that he met and married Audrey Campbell, an outstanding Army nurse in the Medical Service.

After his discharge from the military, he continued his training as Fellow in Surgery at Tulane University, New Orleans, Louisiana, from July 1950 through June 1951. The balance of his training was received at the University of Minnesota as a Fellow in Surgery from July 1951 to November 1953. He was a senior resident in Surgery from July 1953 to November 1953. He served under the tutelage of Dr. Alton Oschner at Tulane and Dr. Owen Wangenstein at Minnesota. Among his colleagues at the University of Minnesota was Dr. Norman Shumway, presently at Stanford University a leader in heart transplant surgery in this country. Dr. Delancy earned his Master of Science degree (Surgery)

at the University of Minnesota through scholarly, original research in several areas: "The effect of surgery on the extracellular water and electrolyte," "Surgical treatment of pulmonary tuberculosis," "The evaluation of cortisone, thromboplastin, and inositol phosphatide in the therapy of severe experimental burns in rats." Commencing his private practice career in Atlanta, Georgia, he was persuaded by several friends and colleagues in Savannah to move here. To the great benefit of this community, he accepted the offer and became a member of the Georgia Medical Society in January 1955. He was a staff member of St. Joseph's Candler, Memorial, Telfair and Georgia Infirmary.

After several years of solo practice he formed a partnership with the late Randall Winburn for several years and subsequently was the senior partner of Paulsen Square Surgical Associates professional group, at that time a four physician surgical group.

**D**r. Delancy was a physician's surgeon. He was well respected among his colleagues, many of whom were his patients as were their families. He was a totally dedicated physician. He was not a member of many important civic groups or social clubs. Although intensely interested in community service and politics, he reserved his time and energy for the care of his patients and the maintenance of standards in the hospitals where he served many hours in staff and committee work. As an active participant in the teaching program at Memorial Medical Center, he eagerly trained scores of surgical residents, many of whom are currently practicing in the Savannah area. In 1987, he was

honored by Memorial Medical Center for his outstanding contribution to that institution, and I quote from the resolution, "Whereas Dr. Delancy is revered as an outstanding surgeon who has brought dignity and honor to his profession and who is held in high esteem by his associates and friends, therefore be it resolved that the members of the Board of Directors, Memorial Medical Center, do express to Dr. Herman Delancy our sincere admiration and gratitude for his service as a member of the Medical Staff and for his unselfish work to further the quality of health care in the community."

His career was cut short by a cerebrovascular accident at the age of 62 in 1985 which permanently disabled him from further work. Further progression of his vascular disease resulted in a massive heart attack which led to his death on November 25, 1987. He is survived by his widow, Audrey, a son, Benjamin, practicing law in San Francisco, and a daughter, Susan, with a prominent accounting firm in Atlanta. He was a member of Temple Mickve Israel.

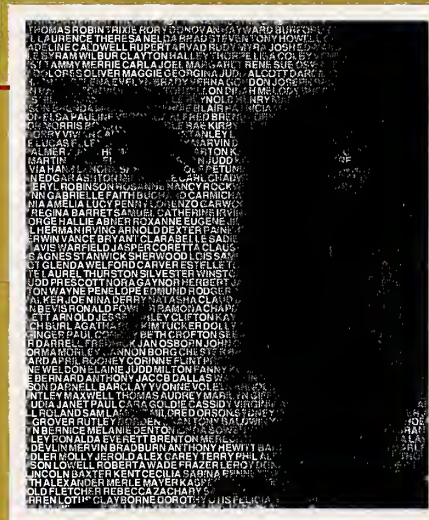
Dr. Delancy was a kind, gentle, caring surgeon and person. His dedication as a physician was equalled only by his devotion to his family. His technical skills were well known throughout our community. Many of Savannah's most prominent citizens were his patients from time to time. The standards of excellence which he maintained will remain a beacon to others for years to come.

*(Reported by Murray C. Arkin, M.D., Mason Robertson, M.D., and Meyer Schneider, M.D., Georgia Medical Society.)*



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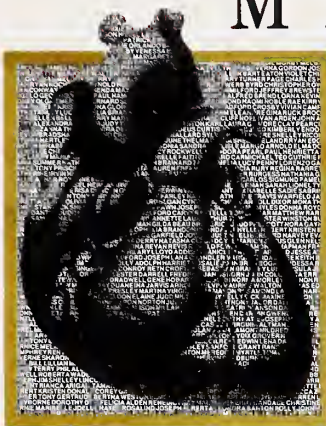
# The one you know best keeps looking better

Please see next page for brief summary of prescribing information.

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 AMMY MERRIE CARLA JO  
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 A JESSICA BERNARD MA  
 E BLAIR PATRICIA MIL  
 ANNON MORRIS BONDIN  
 AHAM ELEANORE GIN  
 MORE CLAY PEARCE G  
 NICOLE PETUNIA HA  
 LEE CHERYL ROBINS  
 RVIN HUNTER NEVIN  
 T TLAND COLEMAN  
 ER PAINE JANE SH  
 AWLEY KATHERINE  
 EIRMA MYLES JULI  
 INETTE LAUREL TH  
 RANDALL PHYLLIS  
 RION JULIUS GLENN  
 JESSE ASHLEY CLIF  
 ANCHE ROBIN JACQ  
 RK NOAH STEWART  
 ORINNE FLINT PRESL  
 RON MORTON JULIE  
 SHIRLEY HARPER PE  
 OLDIE CASSIDY VIRGI  
 LYDIA GROVER RUTL  
 SIBYL NOEL HUMPHR  
 L BILL LILLIAN MARLE  
 ADE FRAZER LEROY DO  
 S MEREDITH ALEXAND  
 ES MOND TONY HILARY  
 ERTAL LEONORA BART  
 ENNIS CULLEN TABIT  
 RENDAN GUNTHER E  
 MARIO JAYNE MELIS  
 SPER VITO NICHOLA  
 Y JONATHAN SALLY  
 ON SEAN WALDEN RO  
 AT DIANE JENNIFER LE  
 LLEEN DWIGHT MITCH  
 E INGRID CHANNING LIN  
 ANSON ANDREW GALL  
 ER ROXANNE ASHBY HAR  
 A TRIXIE RORY BAYARD CH  
 JOSEPH PAGE JULIE REX RE  
 LEONA RUDY MARCUS SLOAN B  
 RADONNA CRAIG ANNE ELMER P  
 HAM ADELIN HALL EY MILFORD DE  
 ON PRISCILLA WILSON RUPERT HAR  
 ATH STEVEN BRONSON JEAN PETER DIA  
 NE LORNA ROBERT A NOBLE TOM SABINA  
 T MIA BARTLETT BEAU DINAH JIM FRITZ D  
 NE CECILIA TAMARA BEN ROSABELLE JU  
 SLE SIMPSON BERNARD ERROL CORETTA  
 VERETT MARGO LENA LORENZO CLIFF R  
 N MARTIN THOMAS TONY COLEMAN LUCI  
 DEN REBECCA COURTNEY NICOLE BREWS  
 ER RHONDA TURNER MADELINE ELLEN MO  
 OWLER JANET TONY THOMAS ROBERTSON  
 T ROBIN HARDEN BRETT NEIL BORDEN OT  
 T WATSON GEORGIA BARCLAY ODESSA  
 ADWICK APRIL TODD ARDEN LAUR  
 A MABEL SHERWIN PAT IDA GINA  
 ARD ARNOLD HILLIARD SILVES  
 ORA DONAHUE EGAN MURRA  
 AMDEN EDNA MILES ALBER  
 RUSSEL AUDREY ELIDEW  
 NOLD TONY WILFRED CI  
 DAM TYSON LARISSA A  
 ON LIBBY OSCAR PHY  
 OYD PHOEBE ARCH  
 S FRANKLIN LOT  
 MRENEE CHA  
 ANZELDA  
 AS MEGA  
 Y CRY  
 SHEP

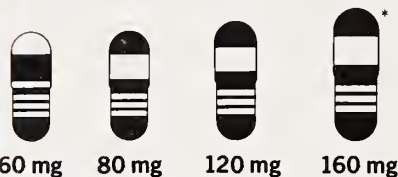


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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

**INDERAL<sup>®</sup> LA** brand of propranolol hydrochloride (Long Acting Capsules)

**DESCRIPTION.** INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

**CLINICAL PHARMACOLOGY.** INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure, and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

**INDICATIONS AND USAGE.** **Hypertension:** INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

**Angina Pectoris Due to Coronary Atherosclerosis:** INDERAL LA is indicated for the long-term management of patients with angina pectoris.

**Migraine:** INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

**Hypertrophic Subaortic Stenosis:** INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

**CONTRAINDICATIONS.** INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

**WARNINGS.** **CARDIAC FAILURE:** Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

**IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE,** continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

**IN PATIENTS WITH ANGINA PECTORIS,** there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

**Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS.** INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

**MAJOR SURGERY:** The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

**DIABETES AND HYPOGLYCEMIA:** Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

**THYROTOXICOSIS:** Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing  $T_4$  and reverse  $T_3$ , and decreasing  $T_3$ .

**IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME,** several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

**PRECAUTIONS. GENERAL:** Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

**CLINICAL LABORATORY TESTS:** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

**DRUG INTERACTIONS:** Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL (propranolol HCl) is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure, or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytin, phenobarbitone, and rifampin accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and lidocaine have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected  $T_3$  concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

**CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY:** Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

**PREGNANCY:** Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**NURSING MOTHERS:** INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

**PEDIATRIC USE:** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS.** Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

**Cardiovascular:** Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresis of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

**Central Nervous System:** Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

**Gastrointestinal:** Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

**Allergic:** Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

**Respiratory:** Bronchospasm.

**Hematologic:** Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

**Auto-immune:** In extremely rare instances, systemic lupus erythematosus has been reported.

**Miscellaneous:** Alopecia, LE-like reactions, psoriasisiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

**DOSAGE AND ADMINISTRATION.** INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

**HYPERTENSION—Dosage must be individualized.** The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

**ANGINA PECTORIS—Dosage must be individualized.** Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

**MIGRAINE—Dosage must be individualized.** The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

**HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.**

**PEDIATRIC DOSAGE—**At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

\*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

#### Reference:

1. Data on file, Ayerst Laboratories.

D7295/188

**WYETH  
AYERST**  
PHILADELPHIA, PA 19101

© 1988, Wyeth-Ayerst Laboratories.





**“E**VEN LOVE CAN MAKE YOU FEEL THIS WAY.” So said Atlanta artist, Margo Owens, when describing the intense pain and isolation expressed in her painting that we used on the cover of this month’s issue. It was that pain and isolation which reminded us of the experience of so many AIDS patients — often isolated from family, friends, and society because of the fatal nature of their disease and the fear and prejudice associated with it. No matter the cause of the pain, the feelings are shared by all human beings, and Ms. Owens has captured those feelings in her painting.

## About the Cover Artist:

# Margo Owens

**B**orn in Atlanta, Ms. Owens attended The Lovett School and graduated from Florida State University in 1985 with a degree in art. Her work frequently incorporates competing color combinations, thereby producing desired levels of tension and contrast within each piece. Her art illustrates an optimistic visual effect as it draws the viewer into the image through vivid colors and pleasing images. Upon closer inspection, however, the underlying intense subject matter of her work is revealed. As such, she captures and then enlightens her viewer by depicting serious themes in a positive manner.

Ms. Owens’ paintings have been purchased by many prominent people in Atlanta and Georgia and neighboring states. She currently works at Tula Showrooms and Studios, located at 75 Bennett St., Atlanta 30309.

### JURIED EXHIBITIONS AND AWARDS

City Hall, Tallahassee, Florida 1985  
 Florida State University Gallery, Tallahassee, Florida 1985  
 Palm Coast Art Festival 1985 — Judge’s Choice Award  
 Mardi Gras 1987, Atlanta, Georgia — Judge’s Choice Award  
 Jubilee 1987, Atlanta, Georgia  
 Decatur Artsfest 1987, Decatur, Georgia  
 Album Cover — “Until Forever,” 1987







## On Loneliness

**R**OY WAS DYING. I knew that and just as surely his wife knew it. Too long ago to remember, she had stopped her schooling, but not her learning, to work at the chicken processing plant. The cancer had bested her husband and as the going got tougher, and more lonely, she called late one night, as I had said she might.

"He's been agurglin' in his throat, kinda like water in his throat. I thought he was adyin'. He's cold, he don't seem to want to talk to me. I thought he was agoin'. He acts like he's in pain, I don't know if he is or not. Me and the grandson turned him over and give him the medicine, but he choked and gurgled. He's not ravin' as much as this morning. I never seen nobody go — I thought I oughta call you like you said to."

There is a loneliness in death. There is a helplessness and a loneliness when AIDS enters one's life. We looked upon it not so long ago as someone else's problem. "Not me. I'm straight. Too bad about John. I knew he was queer all along" — so we said to ourselves. And then into the safety of the sanctuary it came. Blood transfusions, needle sticks, goodness gracious, "safe sex" — all of these loomed menacingly and unpredictably upon our own doorsteps. And so it was that we all came to understand the fear, the uncertainty, the horror, the intense loneliness of AIDS.

**P**erhaps it is not too bad, the simple act of dying, for it comes to us all, but rather the isolation, the stigma and then the

death, awash with insinuations — these are the devastating consequences of AIDS. But beyond and above them all comes the loneliness. It torments, it discourages, it heralds death itself. Our beautiful cover painting poignantly communicates these feelings.

Where does one turn? The treatment at present seems only unpredictably effective, or too costly, or not available at all. Where, then, is the help for those we first want to shun?

**I** did little that night at Roy's house, just sat in a wicker chair at the bedside, held a hand, put an arm around a shoulder. Nothing medical, no science at all. Perhaps I was a counselor. Beyond that, nothing more than comforting company.

**A**nd that is what the AIDS patient needs. Understanding that we too are at risk to one degree or another. Reassurance that death holds no threat that together we cannot conquer. Comfort that loneliness can be overcome by intelligent and caring and informed friends. The virologists, the epidemiologists, the clinicians are hard at work. Somewhere, sometime, somehow they will find the answer. Until that time comes, however, we desperately need to pursue, to organize the counseling and the caring. We need to counteract the loneliness. It could be that most of us are "safe" and yet out of the quietness of our uncertainty comes the haunting thought that, "there but for the grace of God go I." ■

*Charles R. Underwood, M.D.*



*This Journal recently ran an ad for an Atlanta abortion clinic which, in our opinion, was properly licensed and staffed. That action generated criticism from one of our members, an explanatory letter from the Editor to that member, and a final communication from that member concerning the matter. The abortion debate continues to rage at every level of society, be it theological, political or medical. We are publishing these communications not only to inform you of some of the business aspects of your publication but also, more importantly, because they thoughtfully express the feelings of peer individuals concerning an issue that will be before all of us throughout our lifetime. CRU.*

Dear Dr. Hannay:

I appreciate your recent letter concerning the recent ad placed in the Journal of the M.A.G. by the Midtown Hospital and relating to the availability of that institution for the performance of abortions. All too often I hear complaints about what we are trying to do at the M.A.G. but without any effort having been expended on the part of the complainant to let us know how things can be bettered.

I looked into the matter of this ad in the Journal and can only tell you that the Midtown Hospital is a qualified and certified institution. They tend to focus on abortions, of course, and yet we have through the years accepted advertisements from numerous hospitals throughout the state who also are engaged in the performance of abortions although not exclusively so. I certainly have my own feelings and concerns over the abortion issue and yet have never felt that it was within my prerogative to extend or enforce those personally held convictions to other people. In that context and

simply from the standpoint of fairness and equality for everyone, I have found it difficult to reject advertisements from a source that seems to be reputable and which impacts the physicians in the state. I am not trying to justify this ad, please realize that, but simply trying to explain my position in the matter.

And then concerning your membership in the M.A.G., you must not take this one issue and give it such importance that you withdraw from the organization. There are a thousand other efforts underway by the Medical Association of Georgia that favorably impact your life and mine and which it seems to me would be a bit foolish for any of us to throw away.

Again, my thanks for your interest in the *Journal*, and please let me hear from you again in the future should you be willing to help us make this a better medical journal.

*Sincerely,  
Charles R. Underwood, M.D.  
Editor*

Dear Editor,

I appreciate your response to my letter and I, too, also agree that it is not my prerogative to extend or enforce my personal convictions to others. But as a physician and a patient advocate I would ask who speaks up for the 33,000 children that were aborted in the State of Georgia, not to mention the 500 third trimester abortions. (These numbers are based on the information obtained from the Georgia Department of Human Resources in 1986.) There are many grey areas in the field of medicine for which I believe lively discussion can be had and for which I would never withdraw from the Medical Association of Georgia. I always have felt it is better to

work within an organization for change than from the outside on these matters that are grey in their ethical considerations. I cannot, however, support an organization which either actively or *passively* promotes the death of over 33,000 infants, which incidently is almost the entire population of the City of Rome where I live.

Furthermore, just because something is legal does not make it morally right, and there are some things that are so important that we must take a stand for them, irregardless of how popular it may be. As professionals, our standards should be much higher than just what is "reputable and what is legal." Does it not seem odd to you that a baby born, for example, at 26 weeks can in one area of the hospital be aborted while in another area of the same hospital a similar aged baby is aggressively cared for in the neonatal ICU at over a \$1,000 a day expense. What, I would ask you, is the difference in the value of a human life that makes the latter of these infants so much more precious and valuable? It would seem that it is only the whim of the mother, and yet we know there are hundreds, if not thousands of couples throughout the State of Georgia who would love and gladly give love to both of these children irregardless of the feelings that the natural mother had for them. I, too, can remember a time in my medical career when I had somewhat ambivalent feelings toward abortions but the more I become informed the less possible it is for me to stand idly by. It is hard to be a member of an organization which does not have a firm stand one way or the other but rather chooses to straddle the fence and seek middle ground.

*Thank you,  
Keith E. Hannay, M.D.  
Associate Director  
Floyd Medical Center  
Rome*



# BOOK REVIEWS

W. DOUGLAS SKELTON, M.D.

## THE WIDOW'S MITE AND OTHER STORIES

The Widow's Mite and Other Stories, by Ferrol Sams, 218 pp, Atlanta, Georgia, Peachtree Publishers, Ltd. 1987.

**D**r. Sams, a family practitioner from Fayetteville, has made Georgia doctors proud again that he is a professional colleague. *Run with the Horsemen* and *The Whisper of the River* established Dr. Sams as a storyteller with special gifts. He has shared those gifts again in his latest book, *The Widow's Mite and Other Stories*, which is a compilation of short stories. It will make you laugh (more than once), rejoice, feel sad, and marvel at how these little stories can take you on such a trip.

You will meet a varied array of people. There is the widow creatively calculating her tithe, friends trying to short-cut a con-artist, a Christian lady struggling to judge not. I left the book wanting to meet Dr. Joseph Saba of Emory and to refer patients to him. You should meet them all and form your opinions.

Some very important medical issues make their way into these stories. The widow's reflections on psychiatry may deserve a panel at our annual meeting. Gonorrhea, alcoholism, chronic disease, vasectomy, and obscene phone calls influence the people of the stories. Even facts of the malpractice and euthanasia issues are evident.

"Porphyria's Lover" translates narcissism through the tragedy of AIDS. The story closes with verse from Robert Browning's poem by the same name. (Browning's *Porphyria's Lover* is one of a pair of monologues originally published under the title *Madhouse Cells*, a title that emphasized the abnormal state of mind of the speaker.)

Read these short stories by Georgia's storytelling doctor. ■

## NEUROSURGICAL CRITICAL CARE

Neurosurgical Critical Care, edited by Fremont P. Wirth and Robert A. Ratcheson, with associate editors Robert L. Grubb, Jr., Julian T. Hoff, and Martin H. Weiss, volume 1, 253 pp. with illus., Williams and Wilkins, Baltimore, Maryland, 1987.

**F**remont P. Wirth serves as one of the editors of *Neurosurgical Critical Care*. He is Director of the Neurosurgical and Neurological Intensive Care Unit at St. Joseph's Hospital in Savannah. He and his editor colleagues have assembled contributions from experts in many areas of neurosurgical critical care. Other Georgia contributors are Dr. Daniel L. Barrow of Emory University Medical School, Debra Tillman, R.N. of St. Joseph's Hospital in Atlanta, Dr. George T. Tindall of Emory, and Patricia Valenzans, R.N., also of St. Joseph's.

This work is sponsored by the Congress of Neurological Surgeons which, since its formation in the early 1950s, has promoted continuing education for its members. *Clinical Neurosurgery*, an annual volume, first appeared in 1953. In 1977, the Congress began publishing a monthly journal entitled, *Neurosurgery*, which is recognized as a quality addition to the neurosurgical literature.

*Neurosurgical Critical Care* is the first volume of a new publication series entitled, *Concepts in Neurosurgery*. As with *Neurosurgical Critical Care*, future monographs will cover areas intensively and will relate basic science knowledge and theory to practical neurosurgical issues.

*Neurosurgical Critical Care* is an impressive beginning to this new educational effort of the Congress of Neurological Surgeons.

## COME RUN WITH ME

Come Run with Me by Rose Ann Rigby Weaver, M.D., 47 pp, with illus, Vantage Press, Inc. 1987.

**D**r. Weaver lives and practices internal medicine in Madison, Georgia. She coordinates a community wellness program in Madison and her enthusiasm for both fitness and Madison are obvious in her book.

Her personal fitness trail winds by the beautiful antebellum homes in Madison. The homes are so much prettier than the black and white pictures but, having seen many of them, I enjoyed the short notes on past and present ownership. Maybe I will drive over there some day for a jog.

The fitness advice should be known to all of us doctors. The "Eat no sugar" part seems a little excessive to me, especially when you are urged to share with a friend if temptation overwhelms.

Dr. Weaver thinks about the future as she runs. She thinks about some interesting things: government fitness tests for everyone, additional taxes if we fail the test or if we are overweight, smoke cigarettes, or drink alcohol excessively! I began to wonder how much extra pounds would cost or how the government would decide if I drank excessively. That could present a few problems, but Dr. Weaver is correct — we should be more serious about fitness.





# The World's Most Popular K<sup>\*</sup>

**Slow-K<sup>®</sup>**  
potassium chloride  
slow-release tablets  
8 mEq (600 mg)

It means "dependability" in almost any language

\*Based on worldwide sales data on file, CIBA Pharmaceutical Company.  
Capsule or tablet slow-release potassium chloride preparations should be reserved for patients who cannot tolerate, refuse to take, or have compliance problems with liquid or effervescent potassium preparations because of reports of intestinal and gastric ulceration and bleeding with slow-release KCl preparations.

Before prescribing, please consult Brief Prescribing Information on next page.



# The World's Most Popular K

## For good reasons

- **It works**—a 12-year record of efficacy<sup>1</sup>
- **It's safe**—unsurpassed by any other KCl tablet or capsule<sup>2\*</sup>
- **It's acceptable vs liquids**—greater palatability, fewer GI complaints, lower incidence of nausea<sup>2</sup>
- **It's comparable to 10 mEq**—in low-dosage supplementation<sup>3†</sup>
- **It's economical**—less expensive than all other leading KCl slow-release supplements on a per tablet cost to the patient<sup>1</sup>



**Slow-K<sup>®</sup>**  
potassium chloride  
slow-release tablets 8 mEq (600 mg)

For patients who can't or won't tolerate liquid KCl.

\*The most common adverse reactions to potassium salts are gastrointestinal side effects.

†Pooled mean serum potassium following oral administration of 30 mEq K-Tab compared to 24 mEq Slow-K in diuretic-treated hypertensives (n = 20) over 8 weeks.

C I B A

**References:** 1. Data on file, CIBA Pharmaceutical Company. 2. Skoutakis VA, Acchiardo SR, Wojciechowski NJ, et al: Liquid and solid potassium chloride: Bioavailability and safety. *Pharmacotherapy* 1980;4(6):392-397. 3. Skoutakis VA, Carter CA, Acchiardo SR: Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics. *Drug Intell Clin Pharm* 1987;21:436-440.

**Slow-K<sup>®</sup>**  
potassium chloride USP  
Slow-Release Tablets  
8 mEq (600 mg)

**BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE INSERT)**

#### INDICATIONS AND USAGE

**BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.**

1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure; hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function; potassium-losing nephropathy; and certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

#### CONTRAINDICATIONS

Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see OVERDOSAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

#### WARNINGS

**Hyperkalemia** (See OVERDOSAGE).

In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

#### Interaction With Potassium-Sparing Diuretics

Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

#### Gastrointestinal Lesions

Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

#### Metabolic Acidosis

Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

#### PRECAUTIONS

##### General:

The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis per se can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis per se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

##### Information for Patients

Physicians should consider reminding the patient of the following:

To take each dose without crushing, chewing, or sucking the tablets.  
To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.

To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.

To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

##### Laboratory Tests

Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

##### Drug Interactions

Potassium-sparing diuretics: see WARNINGS.

##### Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in animals have not been performed.

##### Pregnancy Category C

Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproductive capacity. Slow-K should be given to a pregnant woman only if clearly needed.

##### Nursing Mothers

The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

#### Pediatric Use

Safety and effectiveness in children have not been established.

#### ADVERSE REACTIONS

One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

#### OVERDOSAGE

The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 ml/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

#### DOSAGE AND ADMINISTRATION

The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

**Note:** Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

#### HOW SUPPLIED

Tablets—600 mg of potassium chloride (equivalent to 8 mEq) round, buff colored, sugar-coated (imprinted Slow-K)

Bottles of 100 ..... NDC 0083-0165-30

Bottles of 1000 ..... NDC 0083-0165-40

Consumer Pack—One Unit ..... NDC 0083-0165-65

Accu-Pak<sup>®</sup> Unit Dose (Blister pack) ..... NDC 0083-0165-32

Box of 100 (strips of 10) ..... NDC 0083-0165-32

Do not store above 86°F (30°C). Protect from moisture. Protect from light.

Dispense in tight, light-resistant container (USP).

Dist. by:  
CIBA Pharmaceutical Company  
Division of CIBA-GEIGY Corporation  
Summit, New Jersey 07901

C87-31 (Rev. 8/87)

C I B A

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## About Our House . . .

**T**HE HOUSE OF DELEGATES is MAG's legislative body, responsible for setting policy for our Association in the coming year.

The House is a democratic institution. All county medical societies in Georgia — MAG has 68 — are entitled to representation in our House, with at least one delegate per society, no matter how small. Larger societies, of course, have a greater voice in the House; our MAG Bylaws grant 1 delegate for every 25 active members. As a result, our 133rd annual House next month will have 273 delegates' seats.

The House has two main jobs: (1) to elect the Association's officers for the coming year; and (2) to debate and vote on the various resolutions and recommendations submitted to it. MAG officers and committees and all county societies (either through their officers or House delegates) may submit resolutions and recommendations.

**E**ach year, the House of Delegates considers some 30 or 40 such items of business. To expedite matters, each resolution or recommendation is assigned by the House Speaker to a REFERENCE COMMITTEE,

composed of eight to ten delegates. During the House, Reference Committees hold hearings so that *any member of MAG* (delegate or not) may express his or her opinion on the matter under discussion. After testimony is heard, each Reference Committee evaluates points made and drafts a report to the House, recommending courses of action on specific issues. On its final day in session, the House then discusses all Reference Committee reports and votes on the issues. In so doing, it sets MAG's policy for the coming year.

Our House of Delegates is therefore a mix of representative democracy (through county society delegates) and of direct democracy (through members' rights to speak at Reference Committees). *But as with all democratic bodies*, our House depends on the individual expression of opinion.

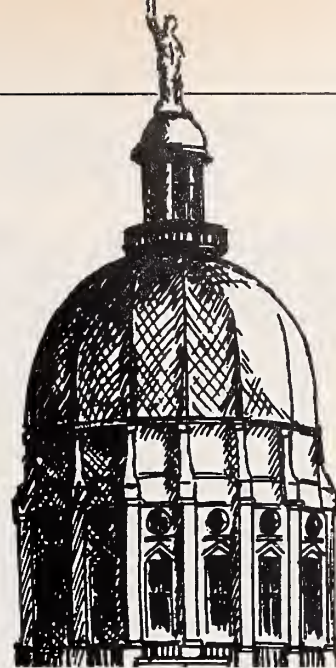
Do you have thoughts or concerns about medicine in Georgia, about our profession, or about our Medical Association? The MAG House of Delegates exists to give you a means to *voice* those ideas. Let us know your views and how we can help you express them by calling our staff at MAG headquarters today.

*James A. Kaufmann, M.D.  
Speaker*

*Jack A. Raines, M.D.  
Vice-Speaker*



# Georgia Legislative Update



**M**ANY AIDS BILLS were introduced in last year's session of the Georgia General Assembly. One of these, HB 107, almost passed with language that was of concern to the legislative leadership as well as to the Governor. After the 1987 session was over, the House leadership decided that in 1988 they would allow only one AIDS bill to pass and that it would be an all inclusive one. Representative George Hooks, Chairman of the General Health and Ecology Subcommittee of the House Health and Ecology Committee, was given the responsibility for drafting the "**Omnibus AIDS Bill.**" The Governor made the Omnibus AIDS Bill part of his legislative package. The Lt. Governor and Senator Pierre Howard, Chairman of the Senate Human Resources Committee, also lent their support to the effort. It has passed the House at the time of this writing and is in the Senate Human Resources Committee.

The Bill contains numerous medical provisions designed to help in the fight against this disease. One of the most important sections affecting the medical community is that which deals with the confidentiality of information about a person who either has or has been tested for HIV. The Bill allows AIDS-confidential information to be disclosed as is other medical information today.

It allows the information to be shared between health providers when it would help either the patient, the provider, or another person at risk of contracting the virus. A physician may — but is not required — to disclose to the spouse or sexual partner that the patient has HIV when the physician determines that the person or child of the person may be at risk of being infecting with HIV. This information may also be reported to the Department of Human Resources, which may contact the person determined to be infected with HIV or may do contact tracing, but in certain cases must contact the spouse.

**T**he bill does not require mandatory reporting of confirmed positive HIV tests by name to DHR, but does allow the Department, when it determines it is reasonably necessary, to establish by regulation that such reporting shall be required. However, anyone ordering an HIV test shall report any confirmed positive results to the Department, but only by age, sex, race, and county of residence. No reporting of results at an anonymous HIV test site is allowed.

There is mandatory HIV testing for several high risk groups: those who are convicted or plead guilty or *nolo contendere* to any AIDS-transmitting crime, inmates in the state prison system, delinquent or

unruly children committed to a state detention facility (with physician determination that the child or others may be at risk), and (when requested by the State Board of Pardons and Parole) those eligible for parole. In addition, testing will be mandatory when a physician at a state health institution determines that the patient may engage in behavior that may either put that person or another person at risk of becoming infected with the virus. This would include people in any state mental health, mental retardation, or substance abuse facility.

**T**esting is not required for those applying for marriage licenses. Those applying will be given a brochure produced by the Department of Human Resources which describes "AIDS, HIV, and the dangers, risks groups, risks behavior, and preventive measures relating thereto," along with a listing of sites where free anonymous tests are conducted. Both of the prospective spouses will be required to sign a form that they have received the brochure.

Unfortunately, the most publicized sections of the bill are the ones that create the criminal acts of AIDS battery and aggravated AIDS battery and the provisions establishing limited mandatory testing. AIDS battery exists when a person, "after obtaining knowl-



# Myths or Facts?

- Even moderate social drinkers may risk liver damage.
- Women are more likely to suffer liver damage from alcohol than men.
- Most victims of liver disease are *not* alcoholics.

All three statements are *true*.

How many did you get right?

Many people are confused about the effects of alcohol on the liver—and *what you don't know can hurt you*.

A pamphlet on *myths* and *facts* tells what you can do to protect yourself and your loved ones. For your free copy, send a stamped self-addressed business envelope to:



**American Liver Foundation**  
Box AL  
Cedar Grove,  
N.J. 07009

edge of being infected with HIV," engages in an activity with another that might put the other person at risk of being infected with HIV, such as sexual intercourse, sharing needles, etc. Aggravated AIDS battery, which may be punishable by at least 20 years in prison, occurs when these same activities are conducted using force, such as rape. The purpose of the criminal section is to deter people from intentionally infecting other people. There is a parallel civil section of the bill that makes the activity a tort, and the perpetrator liable to the victim for damages.

These are the major provisions of the "Omnibus AIDS Bill." It has numerous technical provisions covering court access to records, clinical laboratories, and the protection of body parts and blood

supply. Education is called the "key component" in the fight against AIDS but is not addressed in this bill. It is considered by those who have worked on it a tool in the war against AIDS, not the final solution.

In a recent letter to the editor of the *Atlanta Constitution* about the House version of the proposed legislation, MAG President Jack Menendez stated:

"The Medical Association of Georgia has endorsed this bill as being sound and reasonable. It is neither perfect nor is it an extremist bill on either side. It recognizes the plight of the victims and attempts to protect their rights, but it also recognizes the rights of those who do not have AIDS and attempts to protect them from getting it."

**"IT'S WHAT SMOKING DOES TO YOUR LOOKS THAT KILLS ME."**

"I don't even like to be in a room with people who are smoking. Especially after I've just washed my hair. Or bothered to get all dressed up."

"Besides, I think smoking ruins your image. It's almost like wearing a sign that says you don't feel secure enough to go without cigarettes."

**AMERICAN LUNG ASSOCIATION**  
The Christmas Seal People



# MR UPDATE

## MRI is Rapidly Replacing CT & Myelography For Evaluation of HNP

### LUMBAR SPINE

**HISTORY:** This 38-year-old male complained of recent onset of low back pain radiating to left lower extremity.

**SCAN:** This midline sagittal image demonstrates the high intensity (white) discs lying between the vertebral bodies. The L4-5 disc is herniated posteriorly with a "mushroom configuration" (long arrow). CSF in the spinal canal is gray (short arrow), and this CSF column is indented by the herniated disc material at the L4-5 level (long arrow). Axial images at the other levels demonstrated that the high intensity disc material is contained, and disc herniation can be confidently excluded at all the other levels.



**MRI HIGHLIGHTS:** Lumbar and cervical coil MRI is rapidly replacing myelography and computerized tomography for initial evaluation of suspected disc herniation and suspected spinal stenosis. Standard MR examination shows the entire lumbar or cervical spine, the spinal canal and the paraspinal region. Causes of low back or neck pain and sciatica are well demonstrated without injection of contrast material and without ionizing radiation. The bony structures are well shown, and destructive bony lesions and extraosseous extension of bony lesions are routinely demonstrated on MRI. Intraspinous neoplasms are also confidently detectable.



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*Health Images, Inc.*



# AIDS

## EPIDEMIOLOGY AND FUTURE PROJECTIONS IN GEORGIA

R. Keith Sikes, D.V.M., M.P.H., Joseph A. Wilber, M.D.  
Brian Williams, M.D., Tom McKinley, M.P.H.

**T**HE ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) epidemic continues to escalate in Georgia not only in the Atlanta area but also throughout the state. This article will add to the one presented last year in the *JMAG*,<sup>1</sup> further describing the epidemic and providing some projections on which to base the medical and public health activities for future planning.

### The Epidemic

As of January 1, 1988, Georgia had recorded 1,137 cases of AIDS, with 635 deaths (Figure 1), resulting in a 6-year mortality of 56%. Although 837 (74%) of the cases occurred in the Atlanta area, all other Georgia Department of Human Resources (DHR) health districts reported cases — from 16 in the northeast (Gainesville) district to 78 in the southeast (Savannah, Waycross, Brunswick) district (Figure 2).

Of the 1,137 cases, 1,118 (98%) were in adults and adolescents, while 19 (2%) were in pediatric

patients (<13 years of age) (Table 1). Males accounted for 1,071 (94%) of the cases among adults, females for 66 (6%). Among the 19 pediatric cases, 14 (74%) were in children whose mothers were high risk, i.e. either AIDS positive or IV drug abusers.

### Transmission (Risk) Categories

**Homosexual-bisexual males:** Although homosexual-bisexual males accounted for 275 (67%) of the 409 AIDS cases in Georgia in 1987, this represents a decline from the previous year, i.e., from 75% of the cases to 67% ( $p < 0.02$ ) (Table 2). Similarly, in the U.S. there was a decline in the rate of homosexuals-bisexuals with AIDS, 65% in 1986 and 64% in 1987. Moreover, the national decline was

more marked in homosexuals and bisexuals, decreasing from 72% for the period 1981-1983 to 64% for 1987 ( $p < 0.0005$ ).<sup>2</sup>

**Intravenous Drug Abusers, Heterosexuals:** Although AIDS cases in Georgia among this group have remained rather constant, around 9% (Table 1), there has been a significant increase nationally, from 14% in 1981-1982 to 17% in 1983.<sup>2</sup>

**Heterosexual Transmission:** In 1986, nine (2.6%) people in Georgia contracted AIDS heterosexually, while in 1987, 12 (2.9%) contracted it by heterosexual activity (Table 2). Between 1981-1985, only seven (1.9%) of the AIDS cases were acquired heterosexually. Georgia is following a similar pattern to the U.S. as a whole, where 838 (4%) of the cases were contracted heterosexually in 1987.

**Transfusion, Blood/Components:** In 1987, a total of 19 adults contracted AIDS in Georgia, while in 1986, 17 contracted the disease after receiving HIV-infected blood.

Dr. Sikes is Director of the Office of Epidemiology, Dr. Wilber is Medical Director of the AIDS Program, Dr. Williams is Director of the AIDS Surveillance Unit, and Mr. Tom McKinley is Environmental Epidemiologist, Georgia Department of Human Resources.

Send reprint requests to Dr. Sikes, Office of Epidemiology, Georgia Department of Human Resources, 878 Peachtree St., Atlanta, GA 30309.



FIGURE 1

GEORGIA AIDS CASES AND DEATHS,  
BY DATE OF DIAGNOSIS, 7/81 - 12/31/87  
TOTAL CASES = 1137  
TOTAL DEATHS = 635

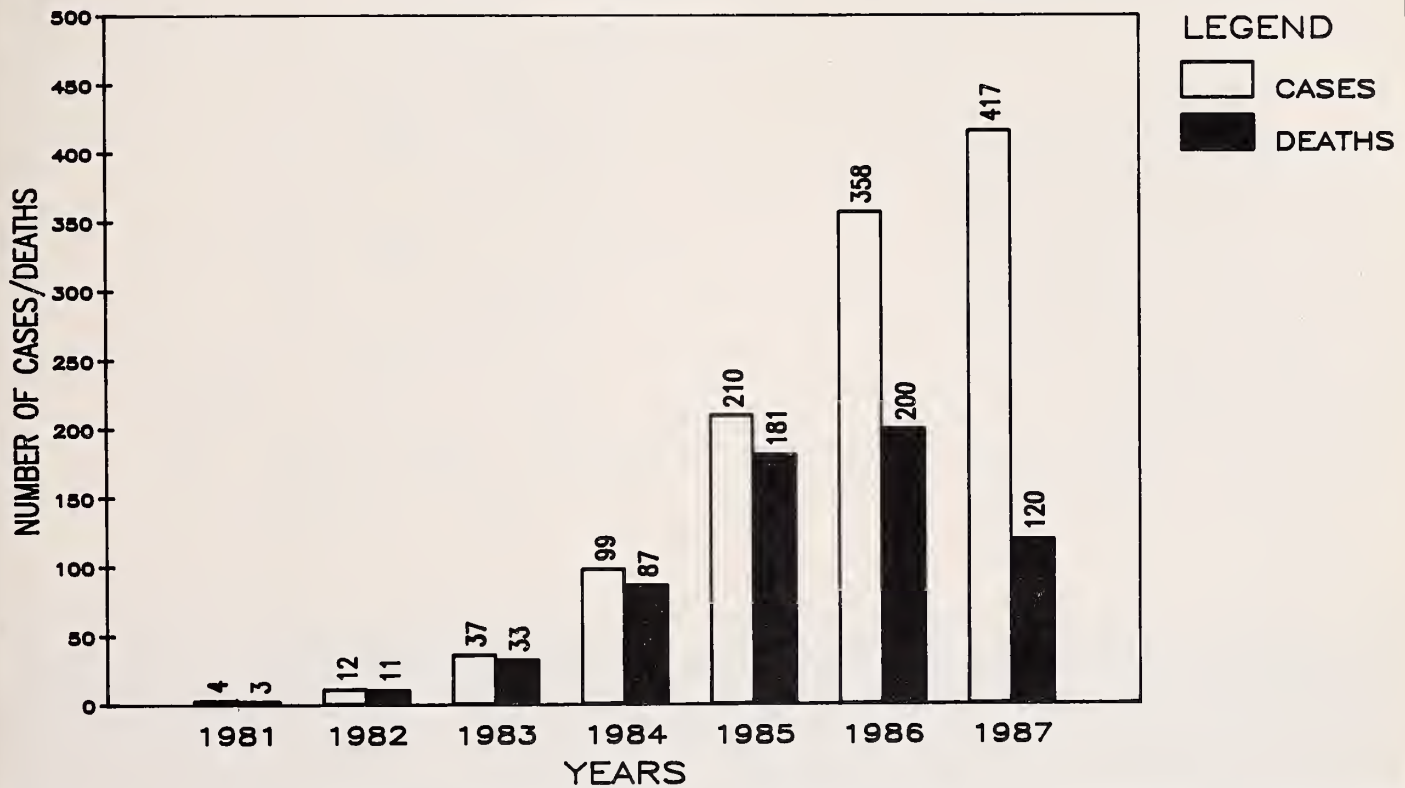


Table 1 — Cases of Aids Transmission Categories By Year of Diagnosis  
Georgia 1981-1987

Transmission Category	Year of Diagnosis									
	1981-84		1985		1986		1987		TOTAL	
	Cases	(%)	Cases	(%)	Cases	(%)	Cases	(%)	Cases	(%)
Homosexual/Bisexual	107	(70.4)	158	(75.2)	263	(73.4)	275	(65.9)	803	(70.6)
IV Drug Homosexual	14	(9.2)	12	(5.7)	26	(7.3)	27	(6.5)	79	(6.9)
IV Drug Heterosexual	14	(9.2)	20	(9.5)	25	(7.0)	39	(9.4)	98	(8.6)
Adult Hemophilia	2	(1.3)	2	(1.0)	1	(0.3)	2	(0.5)	7	(0.7)
Heterosexual Contact	3	(2.0)	4	(1.9)	9	(2.5)	12	(2.9)	28	(2.5)
Adult Blood Transfusion	2	(1.3)	8	(3.8)	17	(4.7)	19	(4.6)	46	(4.1)
Adult Undetermined	7	(4.6)	4	(1.9)	11	(3.1)	35	(8.4)	57	(5.0)
Pediatric (Mother Hi-Risk)	2	(1.3)	1	(0.5)	5	(1.4)	6	(1.4)	14	(1.2)
Pediatric Transfusion	1	(0.7)	1	(0.5)	1	(0.3)	1	(0.2)	4	(0.3)
Pediatric Undetermined							1	(0.2)	1	(0.1)
Total	152	(100)	210	(100)	358	(100)	417	(100)	1137	(100)



These represent 4.7% and 4.8%, respectively, of the total number of AIDS cases during those 2 years, which is approximately two times higher than the national average of 2.2% and 3%, respectively, for the same years (Table 2). In addition, four Georgia children have AIDS as a result of receiving HIV-infected blood components since 1981.

#### Race, Sex Analysis

White males accounted for 610 (76%) of the 803 AIDS cases in the homosexual-bisexual group, while blacks comprised 180 (22%), and Hispanics 13 (2%). Within racial groups, blacks had the highest rate of IV drug abusers (23%) followed by Hispanics (19%), then whites (2%) (Table 3, Figure 3).

Of the 28 heterosexually transmitted cases in Georgia, 22 (79%) were in blacks and six (21%) were in whites. Further, 15 of the 22 heterosexual AIDS cases among

## AIDS Cases by DHR District Georgia, 1981 - 1987

Total Cases = 1137

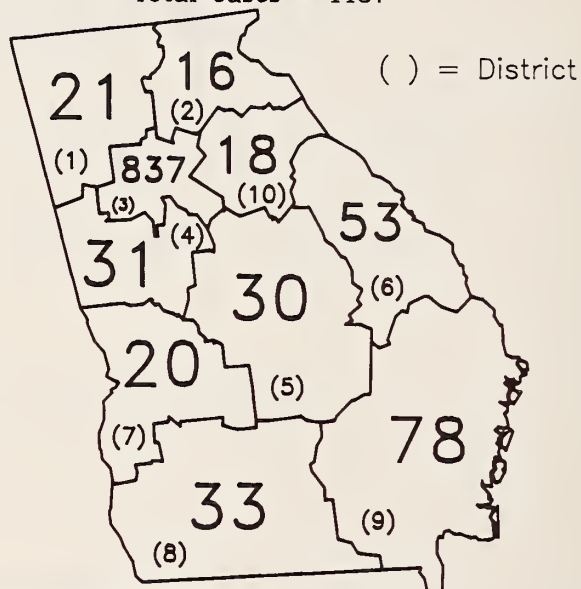


Table 2 — Cases of Aids by Transmission Categories, Twelve Month Totals

Transmission Categories	United States				Georgia			
	Year Ending Jan. 4, 1987 NO.	%	Year Ending Jan. 4, 1988 NO.	%	Year Ending Jan. 4, 1987 NO.	%	Year Ending Jan. 4, 1988 NO.	%
<b>ADULTS/ADOLESCENTS</b>								
Homosexual/Bisexual Male	8465	65.4	13305	63.9	263	74.7	275	67.2
Intravenous (IV) Drug Abuser	2245	17.4	3537	17.0	25	7.1	39	9.5
Homosexual Male and IV Drug Abuser	962	7.4	1464	7.0	26	7.4	27	6.6
Hemophilia/Coagulation Disorder	135	1.0	226	1.1	1	0.3	2	0.5
Heterosexual Contacts	535	4.1	838	4.0	9	2.6	12	2.9
Transfusion, Blood/Components	283	2.2	616	3.0	17	4.8	19	4.7
Undetermined	313	2.4	828	4.0	11	3.1	35	8.6
Subtotal	12938	100.0	20814	100.0	352	100.0	409	100.0

blacks were in females, and three of the six heterosexual cases among whites were in females. No Hispanics have been reported with AIDS as a result of heterosexual transmission.

#### Seroprevalence — HIV Infections

Asymptomatic persons infected with HIV represent a reservoir for

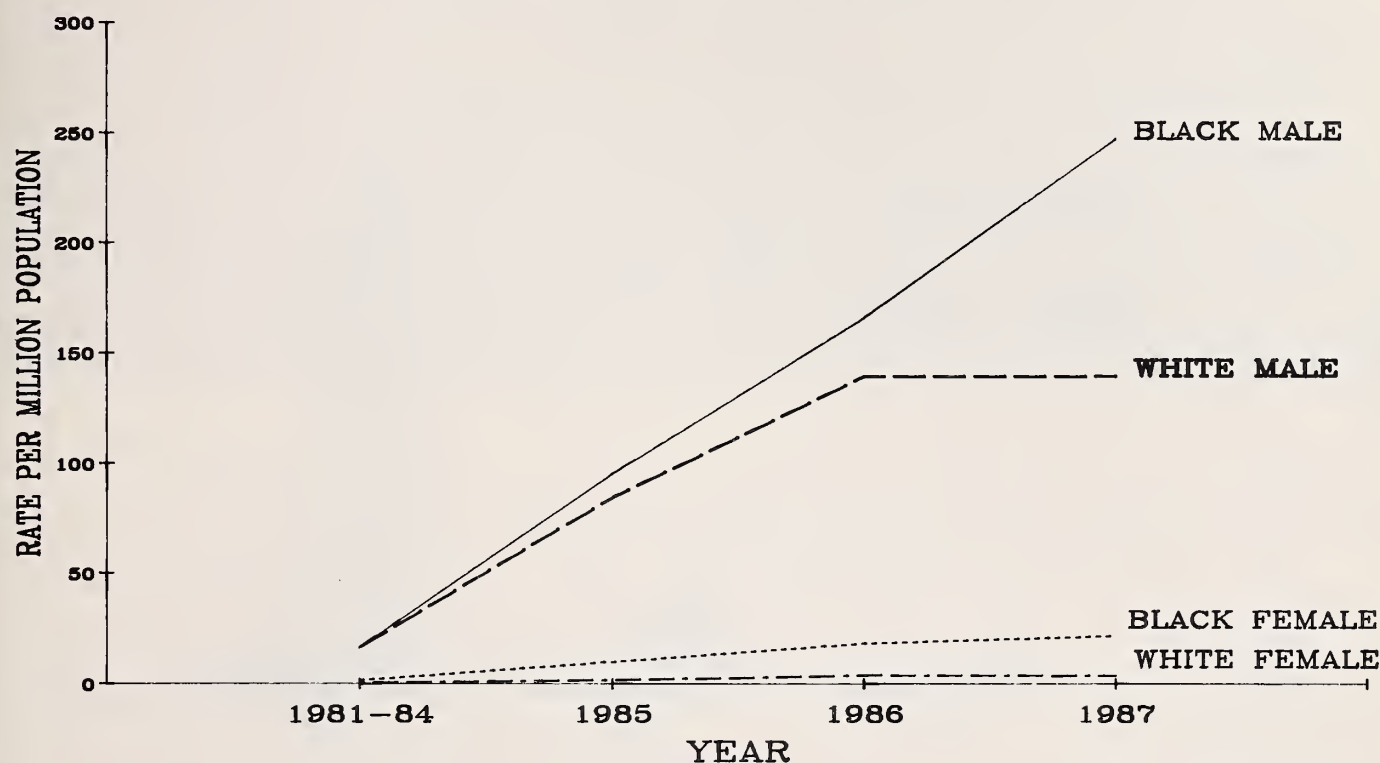
potential spread of the virus. Therefore, it is important to know the size of this reservoir. According to the Coolfont Report,<sup>3</sup> from 1 to 1.5 million people in the U.S. were estimated to be infected with HIV in mid-1986. From that projection, Georgia could be estimated to have between 23,000 and 34,500 people infected with HIV, since approximately 2.3% of the

AIDS cases in the U.S. occurred in Georgia at that time. Some have argued that the Coolfont projection is conservative and that a greater number of individuals have become infected since the report was published. Thus, it is reasonable to estimate that at least 40,000 Georgians might now be infected with HIV.

While current data do not pro-



**FIGURE 3**  
**ADULT\* AIDS CASES**  
**PER MILLION POPULATION**  
**GEORGIA, 1981-1987**



\* Over 13 years of age.

**Table 3 — Cases of AIDS by Race, Sex, and Risk Group**

Risk Group	White		Black		Hispanic		Total		T
	M	F	M	F	M	F	M	F	
Homosexual-Bisexual	610	0	180	0	13	0	803	0	803
IV Drug-Homosexual	53	0	22	0	3	0	78	0	78
Heterosexual	3	3	7	15	0	0	10	18	28
IV Drug Heterosexual	12	1	68	13	4	0	84	14	98
Adult Hemophilia	7	0	0	0	0	0	7	0	7
Adult Transfusion	22	12	9	3	0	0	31	15	46
Adult Undetermined	24	2	24	6	1	0	49	8	57
Pediatric (Mother Hi-Risk)	1	3	5	5	0	0	6	8	14
Pediatric (Transfusion)	1	2	1	0	0	0	2	2	4
Pediatric Undetermined	0	0	0	1	0	0	0	1	1
Total	733	23	316	43	21	0	1070	66	1136

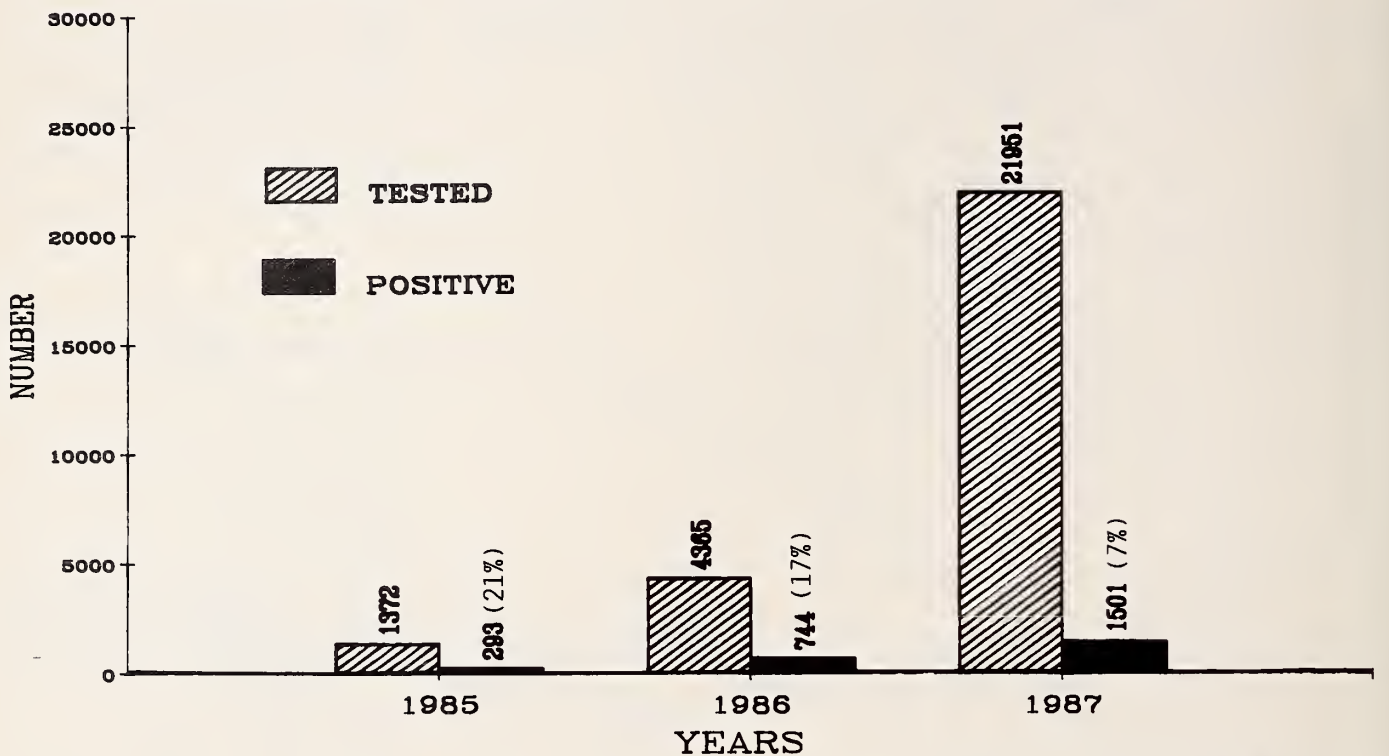
\*Excludes 1 male of unknown race.

vide for a precise estimate of HIV infection in Georgia, there can be no doubt that the prevalence is substantial. Almost 3 years ago, DHR established 11 sites in the state to offer anonymous testing and counseling to persons wanting to be tested for HIV. Data from these locations, referred to as alternate test sites, indicate that:

1. Of the 27,638 people tested anonymously between March, 1985, and September, 1987, a total of 2,448 (9%) were positive. The number of tests conducted by DHR has increased from 1,372 in 1985 to 21,951 in 1987, while the rate of positives has decreased from 21% to 7% (Figure 4).
2. A significantly higher rate of blacks were positive than whites in all sexual preference groups tested (Table 4). Of 4,276 blacks, 459 (11%) were positive, while 549 (6%) of 8,931 whites tested were positive. Similarly, 45% of black male homosexuals, 32% of black bisexuals, and 4% of



**FIGURE 4**  
**SPECIMENS TESTED FOR HIV**  
**STATE VIROLOGY LABORATORY\***  
**MARCH, 1985 – OCTOBER, 1987**

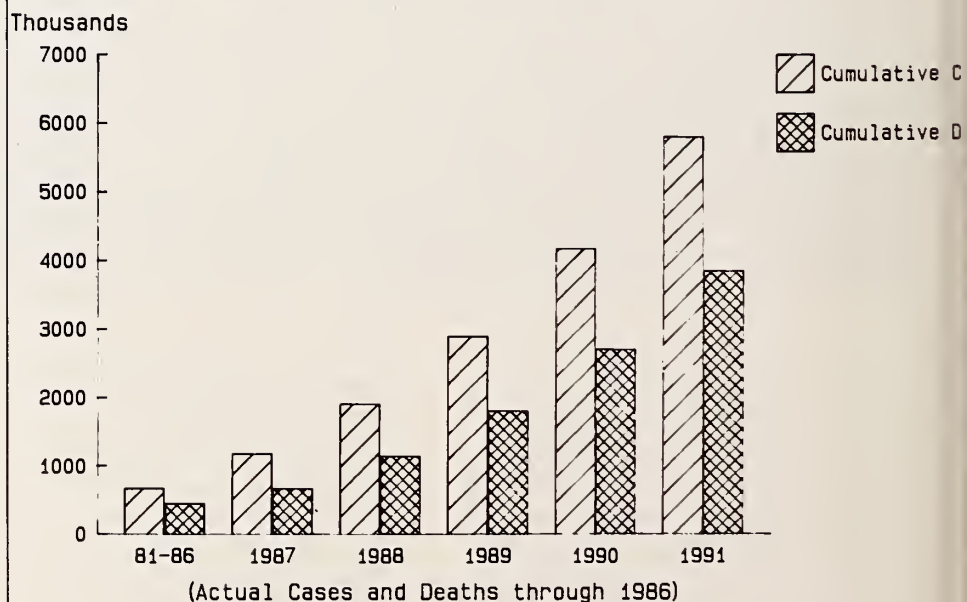


\*Includes Alternate Test Site data.

***A coordinated system of hospital care, outpatient care, home care, nursing home, and hospice care must be developed and put into place now in an effort to reduce unnecessary expenses of prolonged hospitalization.***

black heterosexuals were positive, as compared to 23%, 13%, and 1% of whites, respectively, in those same categories (Table 4).

**FIGURE 5**  
**Cumulative Georgia AIDS Cases and Deaths**  
**Projected through December, 1991**





**Table 4 — HIV Seroprevalence By Race and Sexual Preference**  
**Alternate Test Site Data**  
**Georgia, 10/86-9/87**

Sexual Preference	White			Black			B/W Odds Ratio	95% C.L.
	Tested	Pos.	(%)	Tested	Pos.	(%)		
Homo — Males	1,748	399	(23)	514	232	(45)	2.78	(2.25-3.44)
Bisex — Males	554	70	(13)	328	104	(32)	3.21	(2.25-4.59)
Hetero — Both Sexes	6,629	80	(1)	3,434	123	(4)	3.04	(2.27-4.08)
Total*	8,931	549	(6)	4,276	459	(11)		

\*Note: Excludes 115 pediatric tests (4 positives).

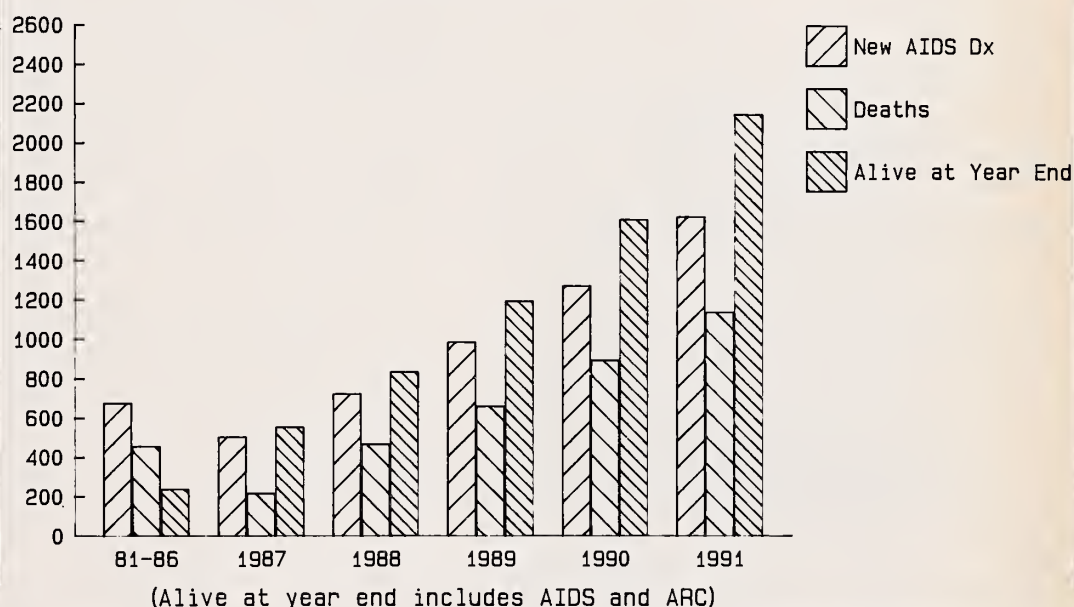
### Projections for the Future; 1987-1991

In its recently published report, *AIDS in Georgia, 1987-1991*, the Georgia Department of Human Resources, (DHR) Five Year Plan, DHR predicted a cumulative total of 5800 to 6200 cases of AIDS in Georgia by the end of 1991.\* Of these AIDS patients, approximately 3800 (66%) will have died. The actual cases and deaths through 1986 as well as the predictions for subsequent years are illustrated in Figure 5.

The average life expectancy after the diagnosis of AIDS is approximately 12 months, with 10-15% of the cases surviving up to 5 years. The estimated new cases and deaths each year from 1987 through 1991 are presented in Figure 6. DHR estimates that in 1991

FIGURE 6

### Georgia New Cases and Deaths by Year Projected through 1991



\*Case Projection Methodology: Georgia used the CDC case projection model introduced at the Coolfont Conference (1986) to project cases of AIDS. This model observes past case doubling time and projects the case doubling cycle forward. The doubling time for the new case reporting has gradually lengthened from 5 months to 15 months. Estimating that doubling time will continue to lengthen to 21 months by early 1991, approximately 6,140 cumulative cases of AIDS will be diagnosed in Georgia through December 1991. This modeling was checked by regression analysis/quadratic polynomial model predicting 5,568 cases and by dividing predicted U.S. cases by 2.2%, the usual proportion of cases represented by Georgia, predicting 5,803 cases.

there will be approximately 1700 new cases diagnosed, plus 500 surviving from previous years, for a total of 2200 living cases, as well as 1200 dying from AIDS during 1991. Also, by 1991 it is estimated that 10,000 Georgians will be alive with a diagnosis of AIDS-Related Complex (ARC), and 10% of these will be severely, chronically ill. Thus, approximately 2300 AIDS cases plus 1000 ARC cases will require extensive hospital, outpatient, and home care health services by 1991.

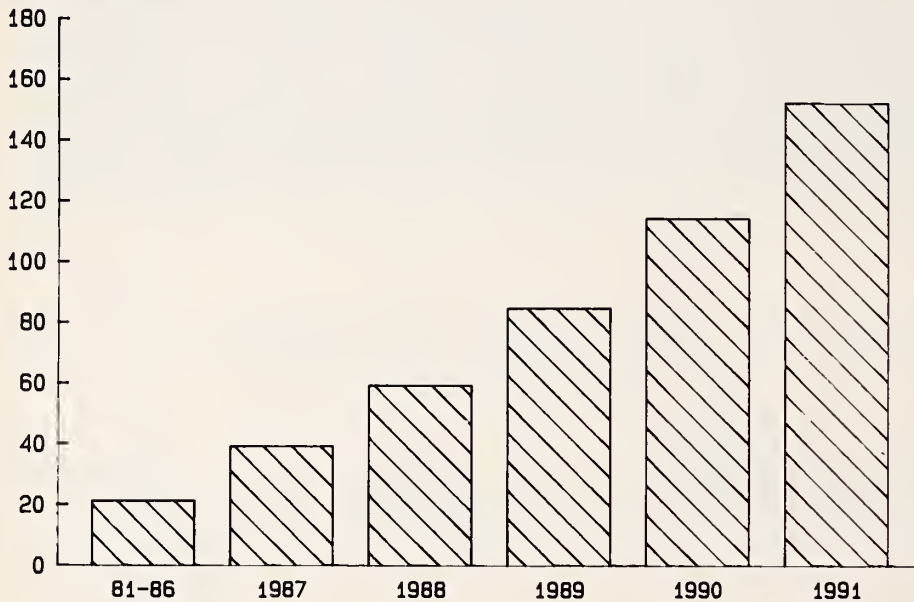
***DHR predicts a total of approximately 5800 to 6200 cases of AIDS in Georgia by the end of 1991, with health care costs of approximately 150 million dollars in 1991 alone.***



FIGURE 7

## Projected Costs of AIDS Care Georgia, by Year through December, 1991

Millions of Dollars



### Projected Costs and Hospital Bed Needs for AIDS Patients.

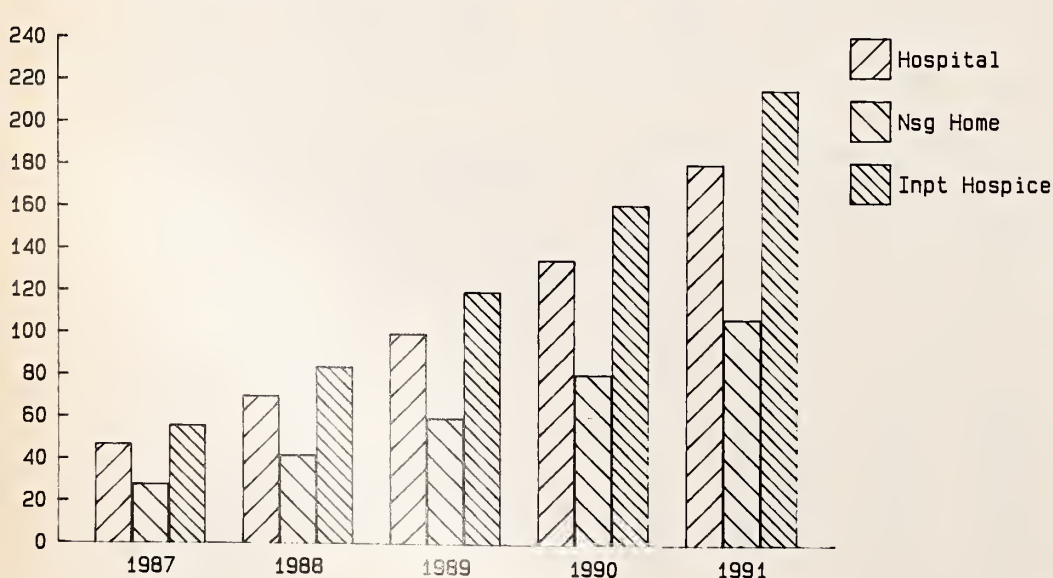
Predicting health care costs for the needs of future AIDS patients is at best an inexact process depending on many unknown factors. What is certain is that most of the cases projected to be diagnosed in the next 5 years are already infected, that their health care costs will be a major addition to total health care costs, and that the system will be severely strained to accommodate these chronically ill and dying people. A coordinated system of hospital care, outpatient care, home care, nursing home, and hospice care must be developed and put into place *now* in an effort to reduce unnecessary expenses of prolonged hospitalization.

The Georgia Hospital Association and the Georgia DHR have each conducted surveys revealing that current AIDS patients are hospitalized approximately 2.25 times per year, with an average length of stay of 15.7 days and daily hospital charges of approximately \$630 to \$790. In addition, each patient is seen 16-20 times per year in physicians' offices or outpatient clinics. As the disease progresses, home care and extensive support services are needed. So far, no nursing home in Georgia has been willing to accept an AIDS patient even if they can pay in full. At least one AIDS nursing home or hospice is a critical need now, and several more will be needed by 1991.

FIGURE 8

## Estimated Bed Capacity Needs for Georgia Cases of AIDS and Severe ARC

BEDS



***As of January 1, 1988, Georgia had recorded 1,137 cases of AIDS, with 635 deaths, resulting in a 6-year mortality of 56%.***



The projected costs for medical care and the projected number of hospital beds that will be needed for AIDS patients based on calculations used in the Georgia DHR Five-Year Plan on AIDS are summarized in Figures 7 and 8. These are crude estimates of the cost and numbers of beds needed to handle AIDS patients. They indicate the urgent need for planning now to establish an efficient and coordinated plan to provide humane and cost efficient out-of-hospital care.

### Discussion

The medical community and public health officials should be able to use the data provided in this paper to direct their efforts in planning to provide clinical services as well as preventive services for the future. It is clear that Georgia has an AIDS epidemic which will continue to spread to all parts of Georgia, since all health districts have reported cases of AIDS, and HIV positives have been reported from almost all alternate test sites.

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***A significantly higher rate of blacks were positive (for HIV) than whites in all sexual preference groups tested (at DHR alternate test sites).***

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The data clearly indicate that Georgia's AIDS cases and HIV-infected people have recently begun to level off in whites and decrease in homosexual-bisexual males. However, cases continue to increase sharply in black males and to a lesser extent in black females,

both of whom have a high proportion of IV drug association. The need to direct AIDS education and prevention efforts to these groups as well as to heterosexuals is very important. Education regarding HIV transmission has apparently caused a significant decrease in AIDS cases in Georgia and the U.S. among homosexuals and bisexuals.

A critical area that needs more effort is to have a better estimate on how many people are infected among high risk groups in Georgia. To that end, DHR has planned several seroprevalence surveys in Atlanta and throughout Georgia. The 1986 Coolfont Report, suggesting that Georgia had at least 23,000 to 34,500 HIV-infected people is similar to the number that DHR estimates — between 30,000 and 60,000.

The complexity of determining the number of people infected is demonstrated by efforts to use the present HIV data that are the only sources available for projection: (1) Alternate test sites with 8% positive overall but with approximately 30% of the male homosexuals being positive and 3% of heterosexuals being positive; (2) Military recruits in Georgia having a rate of approximately 43 per 10,000 (3 times the national average); (3) The American Red Cross where the rate of HIV donors has been approximately 6 per 10,000 in Georgia, and (4) Special studies where the rate in Georgia sexually transmitted disease (STD) clinics has been approximately 3%.

The Red Cross data would suggest that for the group which is least likely to be infected 3,000 people might be carriers of HIV infection. If the military rates were applied, 25,800 might be infected, and if the STD clinic data or the alternate test site data were applied, over 70,000 people might be infected.

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***The medical community and public health officials should be able to use the data provided in this paper to direct their efforts in planning to provide clinical services as well as preventive services for the future.***

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### Summary

The AIDS epidemic continues to grow in Georgia, with the number of reported cases doubling approximately every 15 months. Georgia continues to be eighth in the nation in total cases of AIDS and also eighth in cases per capita. Comparing 1986 and 1987 surveillance data, AIDS shows an increase in the proportion of cases occurring in blacks compared to whites and a decline in the proportion of cases in homosexual/bisexual men.

Seroprevalence studies of HIV infection show a marked excess of HIV positive results in blacks.

DHR predicts a total of approximately 5,800 to 6,200 cases of AIDS in Georgia by the end of 1991, with health care costs of approximately 150 million dollars in 1991 alone.

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# The Prevalence of Human Immunodeficiency Virus, Hepatitis B, and Syphilis Among Female Prostitutes in Atlanta

Terri Leonard, M.A., Jeffrey J. Sacks, M.D., M.P.H., Adele L. Franks, M.D.,  
R. Keith Sikes, D.V.M., M.P.H.

## Introduction

**A**S THE NUMBER of cases of acquired immune deficiency syndrome (AIDS) increases in the United States, so does concern about further sexual transmission of the human immunodeficiency virus (HIV).<sup>1</sup> Female prostitutes may constitute a population at high risk both for contracting and transmitting HIV.<sup>2</sup> To determine the prevalence of HIV infection among female prostitutes and to correlate HIV seropositivity with various high-risk behaviors, the Centers for Disease Control (CDC) conducted a multicenter study in Atlanta, Colorado Springs, Las Vegas, Los Angeles, Miami, Newark/Jersey City/Patterson, and San Francisco. Each center followed the same protocol, although the sample sizes and methods of recruitment varied. Preliminary aggregate findings for

## Abstract

**A**S PART OF a multicenter study of female prostitutes in the United States, 123 women in Atlanta, Georgia, were tested for markers of infection with human immunodeficiency virus (HIV), hepatitis B virus (HBV), and syphilis and were interviewed for prevalence of risk factors. The median number of estimated lifetime sex partners per woman was 500 (range = 3 – 52,000). Fifty-three percent of the women had used drugs intravenously (IV). Fifty-seven percent had had sex with men at increased risk of HIV infection. Nearly 70% of the women used condoms at least some of the time during vaginal intercourse with customers; but only 26% used a condom during each such encounter. Among participants, markers for past infection were found in one woman (0.8%) for HIV, 43 (35%) for HBV, and 16 (13%) for syphilis. Although this study suggests that HIV infection has not spread extensively among the study participants, the high prevalence of HBV markers, IV-drug use, and unsafe sex practices suggests that prostitutes are at increased risk of future infection with HIV unless preventive measures are taken.

the seven centers have been reported elsewhere.<sup>3</sup> This paper summarizes the study conducted in Atlanta by the Georgia Department of Human Resources.

## Methods

Participants were women who had exchanged sex for money or drugs at least once since 1978. They were recruited by a variety of methods including: flyers; advertisements in local newspapers; personal interaction with women soliciting clients on the streets, in bars, clubs, houses of prostitution, and escort agencies; visits to institutions for women (halfway houses, shelters, and correctional agencies); and contacts with a prostitutes' rights organization.

Consent was obtained and participants were counseled about study procedures, the tests, and interpretation of results. Each

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study participant was given a number to identify her laboratory samples and obtain her test results. A standard interview was conducted which included sexual history, contraceptive use, and drug use. Results and post-test counseling were available to participants upon request.

A 7-10 ml tube of blood was collected from each woman and tested at CDC laboratories. Serum was tested for HIV antibody by enzyme immunoassay (EIA) and Western blot; a specimen was considered positive if both tests were reactive. Tests for hepatitis B included hepatitis B surface antigen (HBsAg), hepatitis B surface antibody (anti-HBs), and hepatitis B core antibody (anti-HBc). For detection of syphilis, a positive rapid plasma reagin (RPR) test result was confirmed by a fluorescent treponemal antibody test (FTA) or microhemagglutination assay (MHA).

## Results

From February, 1986, through February, 1987, a total of 123 eligible women were enrolled. Thirty-five percent of the women were recruited from institutions for women; 20% from flyers, recruiters, or peers; 19% while working on the streets or in bars; 15% from newspaper ads; and 11% from houses of prostitution. The mean age of participants was 28; the oldest was 51. Of participants, 81 (66%) were white, and 118 (96%) were born in the United States.

Participants had worked as prostitutes for periods ranging from 1 month to 13 years (median = 24 months). Most (88%) worked primarily in the Atlanta area. However, 34% had worked out of state and 6% out of the country for at least 1 month in the last 5 years. Forty-nine percent of the women reported meeting at least some of their clients on the street; 76% at a house of prostitution; 68% by telephone; and 69% by other

means such as in bars, clubs, or by referral.

Estimated number of lifetime male sex partners ranged from 3 to about 52,000 (median = 500). Fifty-seven percent of the women reported having had intercourse with men who were intravenous (IV) drug users, bisexual, from a country with a high prevalence of HIV infection, or had (or later developed) AIDS. Five women reported having sex with men they knew had or later developed AIDS. Thirty-three percent of participants reported having had receptive anal intercourse at least once.

Sexual practices among the participants differed by race. In general, white prostitutes performed a wider variety of sex acts (e.g., fellatio, analingus, use of objects, fisting\*) with both customers and boyfriends (non-paying male sex partners). The mean number of estimated lifetime sex partners was approximately 2,200 for whites and 3,600 for non-whites.

Fifty-four percent of study participants had at least one child, although 78% reported at least one past pregnancy. The total number of reported pregnancies was 271, with 129 live births. Seven women (6%) were pregnant at the time of interview.

Fifty-three percent of partici-

pants reported having used drugs intravenously. Of these IV-drug users, 78% had shared needles with others. Of all participants, 39% had boyfriends who used IV drugs.

Nearly 70% of the women reported some use of condoms during vaginal intercourse with customers; 26% always used them during vaginal intercourse with customers. On the other hand, over 70% of women never used a condom during vaginal intercourse with their boyfriends (Tables 1-2).

## Prevalence of Antibody to HIV

Only 1 (0.8%) of the 123 study participants was HIV-antibody positive. This 21-year-old woman was from southern Florida and had worked as a prostitute for 7 years in at least 13 other states. She had previously tested positive for HIV antibody in Ft. Lauderdale where she had been arrested for prostitution. She had a history of IV-drug use, needle-sharing, and frequent visits to shooting galleries (places where users buy and inject drugs). She reported always using condoms for intercourse with clients and did not engage in receptive anal sex. Because she preferred manual sex (i.e., masturbation), the estimated total number of partners with whom she had in-

**TABLE 1 — Frequency of Condom Use Among Atlanta Prostitutes with Customers by Type of Sexual Activity, 1987**

Sexual Activity	No. (%) of Prostitutes			
	Doesn't Engage in Activity	Engages in Activity with Customers		
		Always Uses Condom	Sometimes Uses Condom	Never Uses Condom
Penis in Vagina	4 (3.3)	32 (26.0)	52 (42.3)	35 (28.5)
Penis in Mouth	15 (12.2)	19 (15.4)	32 (26.0)	57 (46.3)
Penis in Rectum	91 (73.9)	4 (3.3)	3 (2.4)	25 (20.3)

Note: percents may not add to 100 because of rounding.

\* Inserting fingers, hands, or fist into rectum.



TABLE 2 — Frequency of Condom Use Among Atlanta Prostitutes with Boyfriends by Type of Sexual Activity, 1987

Sexual Activity	No. (%) of Prostitutes			
	Doesn't Engage in Activity	Engages in Activity with Boyfriends		
		Always Uses Condom	Sometimes Uses Condom	Never Uses Condom
Penis in Vagina	3 (2.4)	9 (7.3)	22 (18.9)	89 (72.4)
Penis in Mouth	19 (15.4)	4 (3.3)	8 (6.5)	92 (74.8)
Penis in Rectum	83 (67.5)	2 (1.6)	2 (1.6)	36 (29.3)

Note: percents may not add to 100 because of rounding.

TABLE 3 — HBV Marker Positivity by Risk Factor, Atlanta Prostitutes, 1987

Risk Behavior	Percent HBV Marker Positive*		RR (95%CI)†
	Behavior Present	Behavior Absent	
Past IV drug use	46 (30/65)	22 (13/58)	2.1 (1.2-3.4)
Shared needles	50 (25/50)	25 (18/73)	2.0 (1.3-3.3)
Visited gallery‡	58 (22/38)	25 (21/85)	2.3 (1.5-3.7)

\* Number HbsAg, anti-HBs, or anti-HBc positive/Number tested × 100.

† Rate Ratio and 95% test-based Confidence Intervals (4).

‡ Place where drug users buy and inject drugs.

tercourse was 15. She also had markers indicating past hepatitis B infection.

*Prevalence of Antibody to Syphilis and Hepatitis B Virus (HBV)*

Among 122 women with sufficient sera for study, 16 (13%) had evidence of prior syphilis infection.

Markers for HBV were found in 43 (35%) participants. Women who used IV drugs, shared needles, or visited shooting galleries were significantly more likely to be seropositive than women who did not have a history of such behaviors (Table 3). The mean number of estimated sex partners was approximately 4,900 for women who were seropositive and 1,500 for seronegative women ( $p = 0.05$ ,  $t$  test). Three (7%) women with markers for HBV were HBsAg positive, indicating an infectious status; one of these women was pregnant.

**Discussion**

Among the Atlanta prostitutes who participated in this study, the prevalence of HIV infection was 0.8% ( $1/123$ ). This rate is not of the magnitude reported among prostitutes in areas where the overall population prevalence of HIV is high. In Africa, for example, it is estimated that from 0.7-18% of the general population may be infected with HIV.<sup>5</sup> Correspondingly, studies in African cities have shown high rates of HIV antibody (27%-88%) among female prostitutes.<sup>5</sup> Likewise, in some areas of the United States with a high overall prevalence of HIV infection, such as Miami, New York, and San Francisco, high rates of HIV infection have been found among female prostitutes (18.7%, 57.1%, 6.2%, respectively).<sup>3</sup>

Prostitutes in the U.S. may be at increased risk of contracting HIV infection both sexually and intravenously. Prostitution is often as-

sociated with IV drug use;<sup>6</sup> in our study, over half the participants gave histories of IV drug use. Regarding sexual transmission, 57% reported having sex with men at high risk of HIV infection, only 26% used condoms during each act of vaginal intercourse with customers, and only 7% used condoms consistently with their boyfriends.

The rates of HBV and syphilis markers among our study participants were relatively high (35% and 13%, respectively). Given the similar mechanisms of HBV and HIV transmission, and the independent role that syphilis may play in the acquisition of HIV infection,<sup>7</sup> our findings further support the conclusion that these female prostitutes are at increased risk of future HIV infection.

It must be noted that the recruitment methods for participants in our study are unlikely to have generated a strictly representative sample of all prostitutes in Atlanta. Therefore, generalizing from our data must be done cautiously. Nevertheless, preventive measures are clearly needed. Education regarding the importance of consistent condom use for prostitutes and their customers combined with efforts to decrease needle-sharing among IV drug users could play a significant role in reducing the risk of HIV transmission.

The issues of prostitution and AIDS are complicated by the illegality of the sex industry in most of the United States. It is unlikely that the existence of prostitution or its illegality will change substantially in the future. Meanwhile, health officials and policymakers should develop and implement programs to help prostitutes and their sexual partners avoid HIV infection.

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(Continued on p. 167)



# Transfusion-Related HIV Infection

Brenda J. Grossman, M.D., Alfred J. Grindon, M.D.

**T**HE CENTERS FOR DISEASE CONTROL (CDC) reported the first presumptive case of transfusion-related acquired immunodeficiency syndrome (AIDS) in 1982.<sup>1</sup> The patient had hemophilia, was being treated with Factor VIII concentrate (AHF), and denied any known high risk activities. In the same year, a 20-month old infant was reported to have AIDS after receiving multiple transfusions.<sup>2</sup> Transfusion-associated AIDS (TAA) now accounts for approximately 2% of adults and 14% of children reported to have AIDS.<sup>3</sup> In Georgia, there have been 40 reports of TAA in adults and 4 in children, representing 4% and 29%, respectively, of the total reported cases of AIDS. There may be many more cases of infected recipients nationally and in Georgia, since these have all met updated strict CDC criteria for the diagnosis of AIDS. TAA has significance not only with regard to the safety of the blood supply, but also because understanding TAA will help in understanding the epidemiology of AIDS in general, since the specific time of infection can often be identified.

AIDS has been reported in recipients of whole blood, red blood

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***Using the current prevalence of confirmed anti-HIV in the volunteer donor population of 0.02% and a sensitivity of the EIA screening test of 98%, one can estimate the current risk of transmission-associated HIV to be 1/250,000 units transfused.***

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cells, platelet concentrates, plasma, and clotting factors, but not in recipients of immunoglobulin, albumin, plasma protein fraction, or the hepatitis B vaccine.<sup>4</sup> Recipients of incriminated blood products who received blood before March 1985 are at increased risk for HIV infection. Those recipients at particular risk in this group include those who received

pooled plasma derivatives such as AHF, those who live in areas where HIV infection has a relatively high prevalence in the general population, and those who received many units of blood components. Peterman and coworkers have developed a mathematical model for estimating the risk of HIV infection in recipients of blood products.<sup>5</sup> They concluded that 1,200 recipients of blood products are alive today with HIV infection as a result of transfusions before the spring of 1985. Another measure of the risk to recipients of untested blood has been the so-called "look-back" program. In this program, recipients of untested blood, from donors later found to be anti-HIV positive, are notified and tested. In our experience, of those recipients whose results we were able to obtain, 37% were positive.<sup>6</sup>

**T**he advent of anti-HIV testing of all donors in the spring of 1985 dramatically reduced the risk of transfusion-associated HIV infection (TA-HIV). The remaining risk of TA-HIV depends upon the prevalence of HIV infection in the donor population, the effectiveness of transmission by transfusions, the sensitivity of the test

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being used for detecting infectious donors, and the period of infectivity of the donor prior to the development of antibody.

The current tests for the presence of anti-HIV are ideal for screening purposes, with a reported sensitivity of early versions of 98.6%.<sup>7</sup> Routine testing of donated blood was begun in March, 1985, and has proven extremely helpful in reducing the risk of TA-HIV. Blood centers have discarded all units of blood that are positive by the screening test even when they are negative by a confirmatory test. In addition, all blood donors who are positive by screening tests are entered into the data processing system, and if they give blood again, the units are identified as suspect by the computer and again discarded, regardless of the test results at that time.

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***Today, the safest approach to transfusion is the use of autologous blood, donated preoperatively or provided intraoperatively. Currently, this approach is underutilized and should be encouraged where appropriate.***

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Nevertheless, there will still be some falsely negative results, because patients may be infectious before antibody has developed. The length of this "window" is controversial, with reports ranging from 6 weeks to 14 months.<sup>8,9</sup> Using the current prevalence of confirmed anti-HIV in the volunteer donor population of 0.02% and a sensitivity of the EIA screening test of 98%, one can estimate

the current risk of TA-HIV to be 1/250,000 units transfused. Despite the low magnitude of this risk, systems other than complete dependence upon the test must continue to be used to make the blood supply as safe as possible.

Blood centers have been asking donors to defer themselves if they are members of recognized high risk groups since early 1983. The self-deferral mechanism uses a pamphlet describing groups at high risk for HIV infection, with the donor being asked not to donate if he or she belongs to any of these groups. After reading this pamphlet, donors are asked to fill out a questionnaire which asks about symptoms of AIDS or AIDS-related complex, or potential exposure to others at high risk for HIV infection. They are then asked these questions directly in a private environment by a nurse to assure that they understood the questions. This self-exclusion approach has decreased the number of donors at high risk for transmitting HIV infection. Even before anti-HIV testing was implemented, the number of donations from men age 21-30, the number of units positive for hepatitis B surface antigen, and the number of units testing positive for the serologic test for syphilis decreased significantly from the period before this approach was used.<sup>10</sup>

Another important element in reducing the risk of TA-HIV has been the availability of alternate sites for anti-HIV testing. The Department of Human Resources of the State of Georgia was one of the first in the country to develop a system of alternate site testing, which allowed those who sought only a test result to be able to obtain it at a site other than the blood center.

In 1986, a confidential exclusion form was introduced. This form, labeled only with the blood unit number, is given to each donor, who is asked to indicate whether his or her blood should be used for transfusion or testing

purposes only. This form is then sealed, and subsequently opened in the laboratory, where only the unit number identifies the unit as unsuitable for transfusion. Donors are also given the telephone number of the blood center and their unit number, with instructions to call back at anytime if they feel their unit should not be used for transfusion. This form offers the donors, who may be under external pressure to donate, an opportunity to exclude themselves without public embarrassment.

Blood centers have been seeking other ways to improve the safety of the blood supply, such as treating the blood after collection. This has proven to be successful for those products that can be pasteurized, such as albumin and plasma protein fraction. Infection has also been shown not to be transmitted by immunoglobulin. Some derivatives of plasma proteins, such as AHF, lend themselves to heat treatment, which renders this material safe with regard to transmission of HIV infection. Other approaches, such as the use of ultraviolet irradiation with betapropiolactone, or the development of artificial substitutes to provide oxygen-carrying capacity, are under development.

Despite these efforts to improve the safety of the blood supply, donors are still found whose serum contains anti-HIV. For the most part, investigation has shown that these donors are clearly members of high risk groups.<sup>11</sup> It is not clear why they persist in attempting to give blood despite all the safeguards to prevent this from happening. The ultimate solution may be more extensive donor education, which is a part of general public education about HIV infection.

**T**oday the safest approach to transfusion is the use of autologous blood, donated preoperatively or provided intraoperatively. Currently, this approach is underutilized and should be encouraged where appropriate.<sup>12</sup> The



risk of TA-HIV is minimal, but blood transfusion remains potentially dangerous. When autologous blood cannot be used, transfusing physicians and patients need to be assured that altruistic volunteer blood donors, coupled with current systems and tests, have made the blood supply safer than it has ever been.

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# Does the Threat of AIDs in Georgia Justify Distributing Free Needles and Syringes to Addicts?

Judith T. Byrnes

**I**NTRAVENOUS DRUG (IV) users are presently the second largest group of persons developing acquired immunodeficiency syndrome (AIDS) in the United States, second only to homosexual males. IV drug use is a risk factor in 25% (12,627) of the 51,916 AIDS cases in the United States reported to the Centers for Disease Control through January 25, 1988. In Georgia, 16% (180) of the 1,175 cases reported as of February 5, 1988, have been IV drug users. Of these, 100 are heterosexual IV drug users.

Georgia is serving between 500 and 600 IV opiate addicts in its six methadone treatment programs. The National Institute on Drug Abuse estimates that for every one IV user in treatment there are from six to ten who are not. In Georgia, this would mean an additional 3,000 to 6,000 persons using IV drugs.

Once HIV becomes established among IV drug users in a local area, drug use practices become a primary mode for heterosexual and in utero transmission. Control of the AIDS epidemic in the United States will thus require control of AIDS among IV drug users.

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***Early data from the Amsterdam experience indicate that the needle exchange program has not led to an increase in drug injection, nor to a decrease in methadone or drug abuse treatment, nor has it led to observable reduction in the spread of HIV.***

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Studies by Des Jarlais, et al.<sup>2</sup> in New York City indicate that HIV is spread among IV drug users predominantly through sharing injection equipment. Homosexual activity may serve to introduce HIV into a community of IV drug users, and heterosexual activity may serve to spread the virus from IV drug users to persons who do not

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themselves inject, but it is the sharing of drug injection equipment that is the dominant mode of transmission among IV drug users.

**T**here have been a limited number of studies that examine different behavioral factors associated with HIV seropositivity. Three of these are from the New York City area, which has the highest rates of seroprevalence in the United States. Despite the limited number of studies, the findings permit some conclusions about behavioral factors associated with sharing equipment and HIV seropositivity.

The frequency of drug injection was associated with seropositivity in all three studies from the New York area and one conducted in San Francisco. One interpretation of these findings is that prior to any awareness of AIDS, sharing equipment was a normal aspect of injecting illicit drugs. The more one injected illicit drugs, the more likely one was to share equipment and thus become exposed to HIV.

Another behavioral factor that has been associated with HIV exposure across different studies has



been the frequenting of "shooting galleries" which users visit for the purpose of injecting drugs. Shooting galleries permit the sharing of drug injection equipment among large numbers of IV drug users and is equivalent to large numbers of anonymous sexual partners in spreading the virus among homosexual men. This practice may be of importance during the early phase of HIV transmission in a particular geographic area leading to the rapid increase in seropositivity, such as was observed in New York City among IV drug users in the late 1970s.

**A**IDS and IV drug prevention efforts in the United States have focused on increasing IV drug users awareness about AIDS by the use of Street Outreach teams comprised of ex-addicts who frequent neighborhoods known for high drug use. They educate people about AIDS and the risks associated with sharing needles and unsafe sex. They give out condoms, encourage participation in drug treatment programs, make referrals for HIV testing, and tell persons how to sterilize needles if they are not ready to stop using drugs. Studies are showing that these outreach efforts have led to both an increase in the use of sterile equipment and a decrease in the frequency of injection as well as increased numbers of addicts entering drug treatment.

In the Atlanta area, a Street Team of four former addicts sponsored by the Georgia Department of Human Resources has been providing education and outreach services since February, 1986. Preliminary findings of a study conducted in September, 1987, by Latzanich<sup>2</sup> of 90 drug users contacted by the street team found: 88% were male, 12% female; 76% were black, 22% white; 82% were heterosexual, 14% bisexual, 3% homosexual; 62% felt they were at risk of getting AIDS; 41% knew

a person with AIDS; 64% felt addicts should be given free needles to use for shooting drugs; and 39% shared needles frequently, 37% occasionally, and 21% never.

Further data are available from questionnaires completed by persons requesting HIV antibody testing through methadone treatment centers in Georgia.<sup>3</sup> A total of 230 people were tested from February to December 1987: 52% were methadone clients and 42% were referrals from drug treatment programs, criminal justice agencies, the street team, and the sexual and/or needle sharing partners of IV drug users.

A total of 78% were IV drug users. Of these, 67% were white, and 26% black. Forty-six percent of the IV drug users had not been to a shooting gallery. While 6% had been once, 34% had been a few times, and 9% often. When asked if they shared needles with someone else, 3% said they shared all of the time, 7% shared most of the time, 68% shared some of the time, and 16% none of the time.

These indicators about the use of shooting galleries and the practice of sharing needles leave no doubt that we must expand and intensify our education and prevention efforts if we are to stop the transmission of HIV among IV drug users in Georgia.

#### **The Amsterdam Experience**

**O**ne of the most controversial strategies in containing the spread of AIDS is the practice of free distribution of sterile needles to IV drug users. There are currently no such programs in the United States, though both New York City and San Francisco are considering it.

One study of needle distribution is underway in Amsterdam, Holland.<sup>4</sup> Amsterdam is a city with a population of 650,000 in a country of 14 million. Health officials estimate there are 7,000 drug ad-

dicts in Amsterdam and 20,000 in the country. Only 35% of the 7,000, or approximately 2,500, are IV drug users. The other 65% are addicted to other drugs.

In March of 1986, there were 260 known cases of AIDS in Holland. Eight of these were IV drug addicts. A 1986 study of IV drug addicts in Amsterdam conducted by Van der Hoek et al.,<sup>5</sup> showed a seropositivity rate of about 30%. Faced with this, health officials added three distinct new prevention measures to augment drug abuse treatment services: a publicity campaign about AIDS; condom distribution; and a needle and syringe exchange program.

The rationale for these measures was that information about safe sex and safe drug use would lead to behavior changes if the necessary conditions were met: condoms for safer sex, drug free and methadone treatment for those who wanted to get off drugs; and finally the availability of sterile syringes and needles for those IV drug addicts who were not capable or willing to give up their drug use.

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***The presence of shooting galleries and the practice of sharing needles leave no doubt that we must expand and intensify our education and prevention efforts if we are to stop the transmission of HIV among IV drug users in Georgia.***

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***Efforts to prevent AIDS through increasing the use of sterile equipment and through providing drug abuse treatment to stop IV drug use may be mutually reinforcing strategies rather than contradictory ones.***

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The Amsterdam needle and syringe exchange actually started in the summer of 1984. The arrest of a pharmacist in the inner city for the daily sale of syringes to 200 addicts caused concern among drug treatment workers in the community and addicts themselves that there would be an outbreak of hepatitis B. A league of drug addicts, calling themselves the Junky Union, proposed to start a needle exchange program. Although health authorities were not very supportive on this idea, they agreed to try a small experiment. The Municipal Health Service bought disposable syringes and delivered them once a week to the Junky Union and picked up the used ones for disposal. At the program onset, approximately 1,000 syringes were exchanged weekly. In 1985, AIDS became a greater concern, and the program was expanded. Needles were made available through mobile treatment units in converted buses.

Holland's use of "methadone buses" is a unique harm reduc-

tion component for addicts who are not capable or ready to give up their drug use. Methadone is used as a means of contacting drug addicts and to provide a starting point for further stabilization. There are no requirements for counseling or that they stop other drug use — only that they have regular contact with a medical doctor every 3 months. Methadone is given daily from 2 buses at 6 sites in the city.

Since its start in 1984, the number of needles and syringes exchanged has gone from 25,000 to 100,000 in 1985, 400,000 in 1986, and is expected to reach 600,000 in 1987.

**T**he Municipal Health Service began a study in 1987 to evaluate the needle exchange program. Initially, 150 IV drug users will be interviewed, with follow-up interviews of 50 addicts. There will also be interviews with workers who carry out the needle exchange as well as with people who live in areas with a high concentration of addicts. Publication of the study is expected in early 1988.

The preliminary findings from the first 78 addicts interviewed indicate that needle sharing was still occurring over the preceding 2 years, although the majority said they had changed their sharing behavior due to the fear of AIDS. Persons who participated in the needle exchange shared less than other IV addicts. Early data further indicate that the needle exchange program has not led to an increase in drug injection or to a reduction in the demand for either methadone or treatment, nor has it led to observable reduction in the spread of HIV.

**T**hough Georgia's Department of Human Resources is not considering the distributing of sterile needles at this time, one of the issues being studied is distribution of bleach for sterilizing needles. Though there is some evidence that this type of effort has been a successful HIV prevention tool in San Francisco, it is still a controversial issue, seen by some as condoning use of needles and/or drugs.

Preliminary data from New York, New Jersey and San Francisco indicate that educating IV drug users in how to sterilize injection equipment leads them to want to enter treatment for their drug abuse.

Efforts to prevent AIDS through increasing the use of sterile equipment and through providing drug abuse treatment to stop IV drug use may be mutually reinforcing strategies rather than contradictory ones. Given the urgency of containing the AIDS epidemic, we cannot afford to dismiss consideration of any potentially effective prevention method, however controversial.

### References

1. Des Jarlais DC, Freidman SR. AIDS and the sharing of equipment for illicit drug injection: a review of current data. Prepared for the National Institute on Drug Abuse, Washington, D.C., 1987.
2. Latzanich G. Preliminary report on a survey of IV drug users' knowledge, attitudes and behavior regarding AIDS and its transmission. MPH Thesis unpublished, Emory University, Atlanta, GA, 1987.
3. Cornett GJ. A report of data from the Methadone Treatment Center Testing Questionnaires. Georgia Dept. of Human Resources, Div. of Public Health, 1988.
4. Buning EC, Brussel GHA, Stanten G Van. Amsterdam's drug policy and its implications for controlling needle sharing. Unpublished report, Amsterdam, Holland, 1987.
5. Van der Hoek A, et al. AIDS en druggebruik in Amsterdam. Under preparation. ■



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# AIDS Information Resources

**T**HE FOLLOWING is a list of available AIDS informational materials. Although it contains many important and educational resources, it is not all inclusive.

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## WRITTEN MATERIALS

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*"Confronting AIDS: Directions for Public Health, Health Care, and Research"* — a 374-page report by the Institute of Medicine and the National Academy of Sciences, available for \$24.95 (15% discount for orders of five or more). Also available, *"Confronting AIDS: Summary and Recommendations"* for \$1.50. Both from: National Academy Press, 2101 Constitution Ave., NW, Washington, D.C., 20418.

*"Surgeon General's Report on Acquired Immune Deficiency Syndrome"* — a free 36-page report available from: AIDS, P.O. Box 23961, Washington, D.C., 20026-3961, or Inter America Research, 1200E N. Henry St., Alexandria, VA, 22314; 800/342-AIDS.

*Medical Association of Georgia publications* — (938 Peachtree St., Atlanta, GA 30309; 404-876-7535, or 800-282-0224):

*"MAG Report on HIV, ARC, AIDS"* — a 22-page policy plus addendums dealing with HIV testing, confidentiality, counseling, and more.

*"AIDS: Fighting Fear With Facts"* — pamphlet, \$12 per hundred.

*"This is a Mandatory AIDS Test"* — Poster, \$5 each.

### *"Fact Sheets:*

"AIDS"

"AIDS: How the Virus Works"

"AIDS Testing"

"Women and AIDS"

"AIDS and Children"

"AIDS and Health Care Workers"

"AIDS: Blood Donations and Transfusions"

"AIDS and Drug Use"

"AIDS Prevention"

*"Let's Give America the Facts"* — an AMA Medical Society Primer for effectively communicating information about AIDS.

*American Red Cross pamphlets* (contact your local chapter):

"AIDS, Sex and You"

"AIDS and Your Job — Are There Risks"

"If Your Test for Antibody to the AIDS Virus is Positive . . ."

"AIDS and Children — Information for Parents of School Age Children"

"AIDS and Children — Information for Teachers and School Officials"

"Facts About AIDS and Drug Abuse"

"Gay and Bisexual Men and AIDS"

"Caring for the AIDS Patient at Home"

"AIDS and the Safety of the Nation's Blood Supply"

*"Coping With AIDS — Psychological and Social Consideration in Helping People With HTLV-III Infection"* — published by the Department of Health and Human

Services. Available from: Publication No. (ADM) 85-1432, National Institute of Mental Health, Office of Scientific Health Information, 5600 Fishers Ln., Rockville, MD, 20857.

*"AIDS and the Public Schools"* — a 55-page report available for \$15 from: Research Support Services, National School Boards Association, 1680 Duke St., Alexandria, VA 22314.

*Channing L. Bete Co., Inc. publications* — (100 State Rd., South Deerfield, MA 01373, 413-665-7611):

"What Everyone Should Know About AIDS" (also available in Spanish)

"Why You Should Be Informed About AIDS" (for health care workers)

"What Gay and Bisexual Men Should Know About AIDS"

"AIDS and Shooting Drugs" (for intravenous drug users, their family members, and drug treatment counselors)

"What Young People Should Know About AIDS"

*National Technical Information Service publications* — (5285 Port Royal Rd., Springfield, VA 22161, 703-487-4650):

- "Recommendations and Guidelines Concerning AIDS Published in the Morbidity and Mortality Weekly Report, November 1982 through April 1986" Contains all Public Health Services recommendations regarding AIDS during the stated pe-



riod, including precautions for health care workers and allied professionals, guidelines concerning AIDS and the work place, recommendations to prevent parental transmission of the AIDS virus, and recommendations concerning education and foster care of AIDS-virus-infected children.

Order No. PB86-210101. Paper copy, \$7.50; microfiche, \$5.95. (Add \$3 per order for shipping and handling.)

- "Reports on AIDS Published in the Morbidity and Mortality Weekly Report, June 1981 through May 1986"

Also includes all Public Health Service recommendations and guidelines concerning AIDS during the stated period.

Order No. PB86-211455. Paper copy, \$8.75; microfiche, \$5.95. (Add \$3 per order for shipping and handling.)

- "Acquired Immunodeficiency Syndrome: Legal and Regulatory Policy," by William Curran, Larry Gostin, and Mary Clark, Department of Health Policy Management, Harvard School of Public Health. Report of a study conducted by the authors under contract with the Public Health Service. Order No. PB86-248291/AS. Paper copy, \$30.95, microfiche, \$6.50. (Add \$3 per order for shipping and handling.)

"What You Should Know About AIDS" — a pamphlet which gives facts about the disease and information on how to protect yourself and your family. Available from: America Responds to AIDS, P.O. Box 6003, Watville, MD 20850, or 800-342-AIDS.

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#### AIDS VIDEO/AUDIO TAPES

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"AIDS Carriers in My Practice" — This 28-minute videotape, developed through a cooperative agreement between the Centers for Disease Control and AID Atlanta,

alerts physicians and other health professionals to the necessity of identifying and counseling AIDS carriers and persons at risk in order to curb the spread of the AIDS epidemic. This videotape is available in VHS format. Contact Brigitte B. Nahmias, M.D., Medical Video Productions, (404) 834-9955.

"Management of the AIDS Patient: San Francisco General Hospital's Approach" — Aimed at physicians, nurses, hospital administrators, and ancillary-department managers, this 60-minute program covers infection control guidelines, multi-disciplinary approaches to treatment, inpatient and outpatient care, and coordination of hospice care. This videotape is available in VHS and 3/4" formats. Contact Ron Lopp, California Medical Association, (415) 863-5522.

"The AIDS Movie" — a 26-minute film featuring a classroom lesson on AIDS prevention, including why condoms should be used during sexual intercourse and poignant interviews with three young adults with AIDS. Available from: Durrin Films, Inc., 1748 Kalorama Rd., NW, Washington, DC 20009; 202-387-6700.

"AIDS — What Everyone Needs To Know" — an 18-minute film presenting facts and myths about AIDS, and featuring the story of a family in which the husband has AIDS. Available from: Churchill Films, 662 N. Robertson Blvd., Los Angeles, CA 90069.

"Sex, Drugs, and AIDS" — a 20-minute film featuring actress Rae Dawn Chong, which includes scenes of addicts using drugs, brief interviews with AIDS patients, and a discussion about condoms. Available from: O.D.N. Productions, Inc., 74 Varick St., #304, New York, NY 10013; 212-431-8923.

"Beyond Fear" — a three-part documentary by the American Red

Cross and narrated by Robert Vaughn.

"Beyond Fear: The Virus" — Part I illustrates (with computer graphics) the deadly effectiveness of HIV, the virus that causes AIDS. 22 minutes, order No. 18486.

"Beyond Fear: The Individual" — Part II identifies who is at risk from AIDS, how AIDS is and is not transmitted, and how to avoid infection. 17 minutes, order No. 18482.

"Beyond Fear: The Community" — Part III shows how some cities are meeting needs of both patients and the public. 21 minutes, order No. 18484.

To order the complete set, use order No. 18480. Available from: Modern Talking Picture Service, 5000 Park St., North, St. Petersburg, FL 33709; 813-541-5763, or available on loan from the MAG offices by calling 404-876-7535 or 800-282-0224.

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#### SPEAKERS' BUREAU

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In addition, there are several Speaker's Bureaus around the state which can provide speakers on AIDS for County Medical Society, Auxiliary, civic club, or community meetings. Some of the organizations which provide speakers include:

The American Red Cross  
AIDS Education Program  
1925 Monroe Dr., NE  
Atlanta, GA 30324  
404-881-9800

Centers for Disease Control  
AIDS Activity  
Building 6, Room 292  
1600 Clifton Rd.  
Atlanta, GA 30333  
404-329-3479

Medical Association of Georgia  
(MAG) and Auxiliary to the  
MAG  
938 Peachtree St., NE  
Atlanta, GA 30309  
404-876-7535 or 1-800-282-0224



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**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon<sup>®</sup> is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

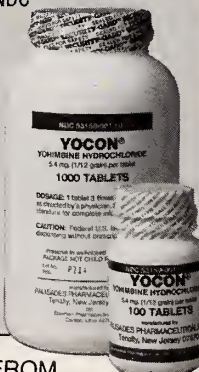
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon<sup>®</sup> 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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### BRIEF SUMMARY

#### CONTRAINDICATIONS

There are no known contraindications to the use of sucralfate.

#### PRECAUTIONS

Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

**Drug Interactions:** Animal studies have shown that the simultaneous administration of CARAFATE with tetracycline, phenytoin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. The clinical significance of these animal studies is yet to be defined.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** No evidence of drug-related tumorigenicity was found in chronic oral toxicity studies of 24 months' duration conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies have not been conducted.

**Pregnancy:** Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

**Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

**Pediatric Use:** Safety and effectiveness in children have not been established.

#### ADVERSE REACTIONS

Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients, adverse effects were reported in 121 (4.7%). Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

#### DOSAGE AND ADMINISTRATION

The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

#### HOW SUPPLIED

CARAFATE (sucralfate) 1-gm pink tablets are supplied in bottles of 100 and in Unit Dose Identification Packs of 100. The tablets are embossed with MARION/1712.

Issued 3/84

#### References:

1. Grossman MI: *Scand J Gastroenterol* 58 (suppl 15):7-16, 1980.
2. Marks IN, in Hellemans J, Vantrappen G (eds): *Gastrointestinal Tract Disorders in the Elderly*. Edinburgh, Churchill Livingstone, 70-81, 1984.
3. Krentz K, Jablonowski H, in Hellemans J, Vantrappen G (eds): *Gastrointestinal Tract Disorders in the Elderly*. Edinburgh, Churchill Livingstone, 62-69, 1984.

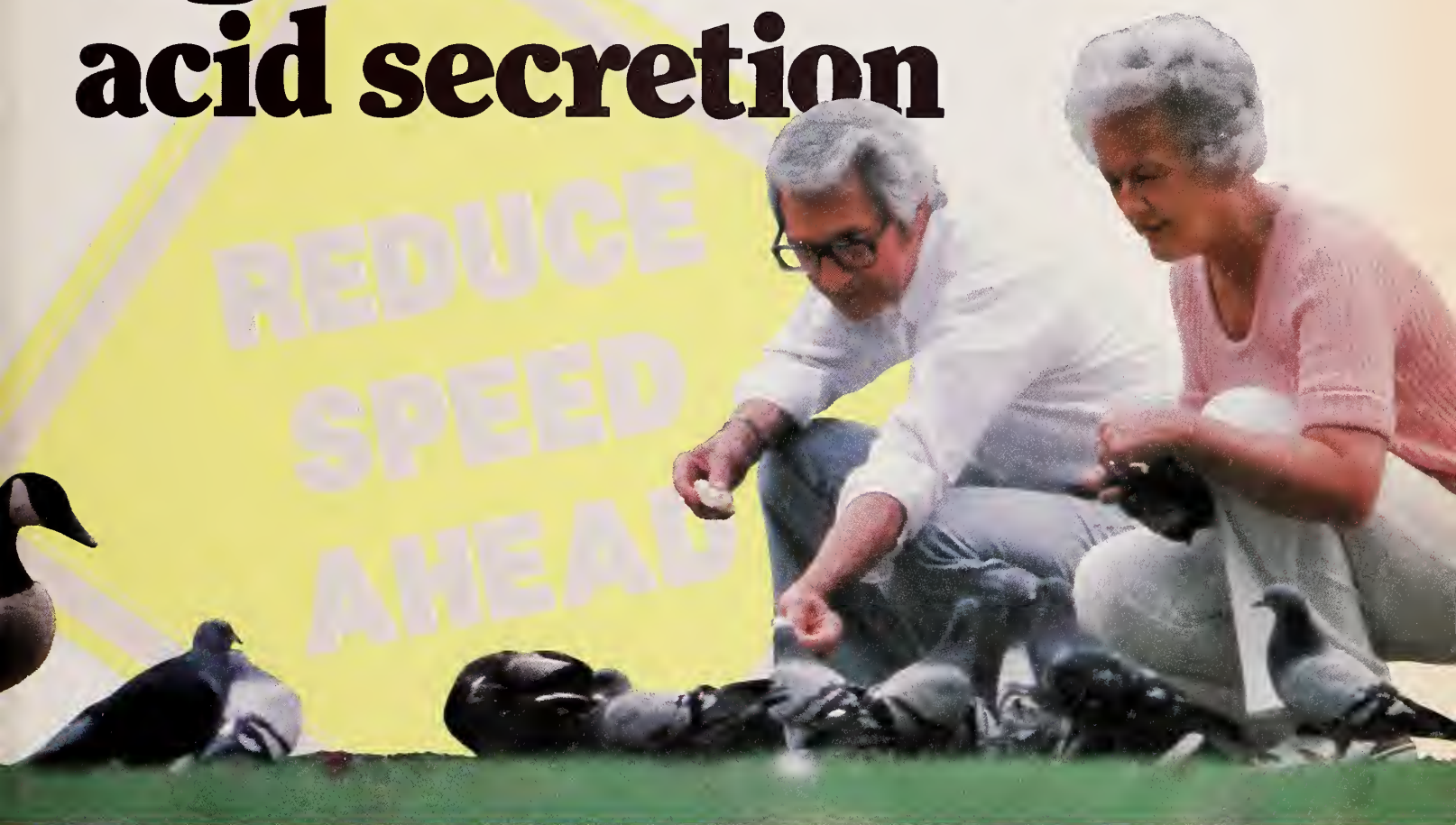
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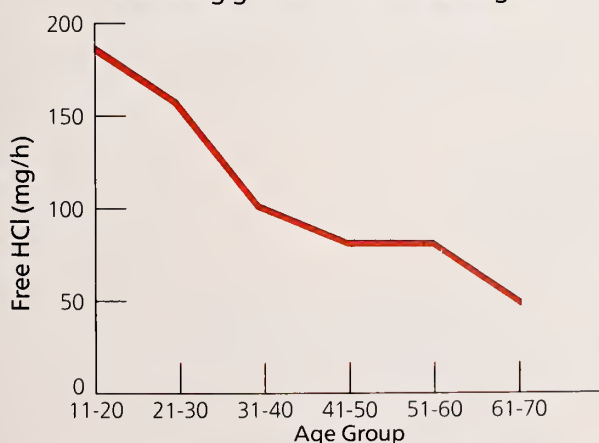
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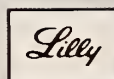
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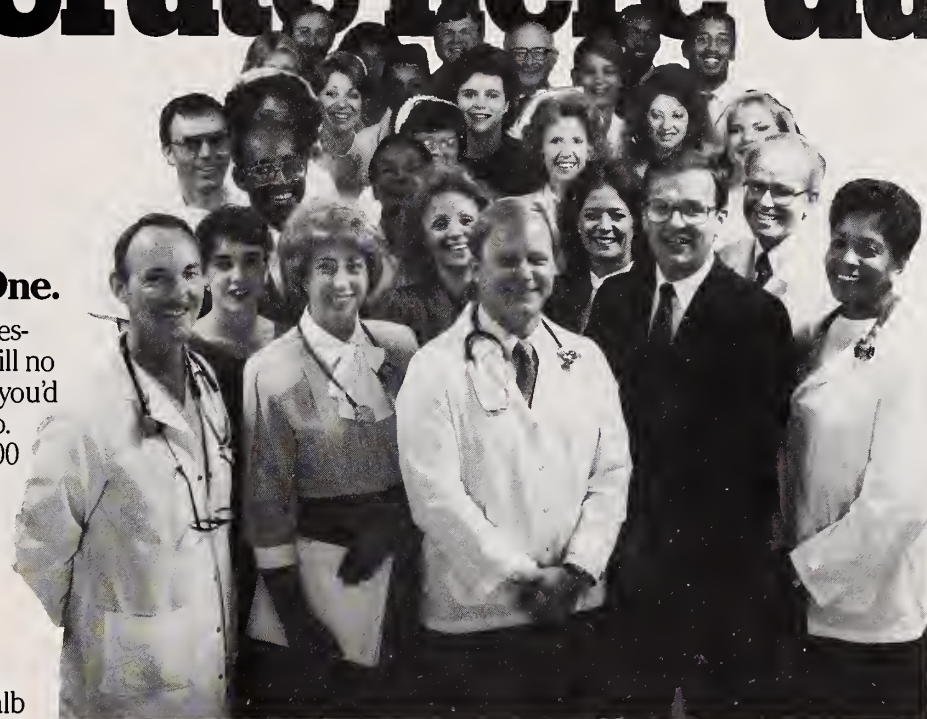
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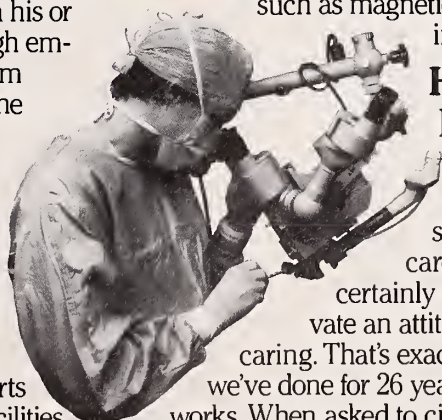
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DE KALB  
GENERAL HOSPITAL







THE MEDICAL ASSOCIATION OF GEORGIA'S  
**1988 HOUSE OF DELEGATES**  
 HYATT REGENCY HOTEL  
 SAVANNAH  
 APRIL 28 — MAY 1

**N**EXT MONTH, the 134th annual meeting of the Medical Association of Georgia House of Delegates, our policy-making body, will be held in Savannah at the Hyatt Regency Hotel, located on the historic Savannah Riverfront.

The House of Delegates is MAG's legislative body, charged by our Constitution with the responsibility for transacting all business of the Association. Most importantly, the House determines MAG's positions on current issues facing the medical profession in Georgia.

All members of the Medical Association of Georgia are cordially invited to attend the several sessions of our House and, through their elected Delegates and Alternate Delegates, to participate in discussion of the issues under consideration.

#### **Reservations for Lodging**

Guest rooms at the Hyatt Regency Savannah Hotel are available for participants in our House meeting. All MAG delegates and officers have received reservation cards from MAG headquarters. All others should make reservations directly with the Ravinia reservations staff, preferably by calling the hotel at 912/238-1234. For this meeting

MAG has secured a discounted room rate of \$87 single and \$97 double occupancy per night.

The Auxiliary to the MAG will hold its 63rd Annual Meeting at the nearby DeSoto Hilton Hotel, April 29-30. Please refer to page [ ] for program information.

A registration desk will be maintained on the second floor, near the Ballroom foyer of the Hyatt for delegates, alternate delegates, directors, and all members. The registration desk will be open:

Thursday, April 28 .....	4:00 p.m.-8:00 p.m.
Friday, April 29 .....	7:30 a.m.-5:00 p.m.
Saturday, April 30 .....	8:30 a.m.-4:00 p.m.

#### **GENERAL SESSION — 7 P.M.**

##### **Thursday Evening, April 28**

**T**he opening General Session will be called to order by MAG President, Jack F. Menendez, M.D. on Thursday, April 28, at 7:00 in the Ballroom.

After opening ceremonies, Dr. Menendez will present MAG Certificates of Appreciation to members who have made special contributions to MAG, and also to other citizens who have distin-



guished themselves in service to the medical profession in Georgia. The President will also honor MAG's members who have been in practice for fifty years or longer; those who have been awarded life membership; and those members who have died during the past year.

Special events during this opening session will be the address of our annual Guest Speaker and the report of the Auxiliary to the Medical Association of Georgia by President Mrs. Roy W. Vandiver. Following will be the presentation of MAG's four special awards:

- **Hardman Cup** — presented to an individual for an outstanding discovery in medicine or surgery, or solution of a major problem in public health.
- **Distinguished Service Award** — for meritorious service reflecting credit and honor to the Association.
- **Civic Endeavor Award** — for outstanding public service and participation in civic activities.
- **Family Physician of the Year** — the recipient of this award is determined by the Board of Directors of the Georgia Academy of Family Physicians.

### FIRST SESSION OF THE HOUSE

Thursday, 8 P.M.

After these ceremonies, James A. Kaufmann, M.D., Speaker, will convene the House of Delegates at 8:00 p.m. in the Ballroom.

The order of business will include:

- nomination of candidates for MAG officers, AMA delegates and alternates.
- announcement of Reference committees for Friday.
- introduction of resolutions or other new business.

### GaMPAC BREAKFAST

Friday, April 29

MAG's Georgia Medical Political Action Committee, GaMPAC, will sponsor a champagne breakfast on Friday morning, April 29, at 7:30 a.m. in the Ballroom.

### Reference Committees

According to the Bylaws of the Association, all resolutions and reports submitted by MAG officers, members, county societies, or committees, which contain recommendations must be referred to a Reference Committee for open hearing.

All MAG members are invited to the Hyatt Regency Savannah Hotel and encouraged to appear and express their views before the Reference Committees. The Committees will open their hearings on Friday, April 29, at 9:00 a.m.

Our House customarily features 6 Reference Committees, each with an agenda of somewhat related issues:

Reference Committee A (Ballroom F) — Tort reform and Membership Issues

Reference Committee B (Ballroom E) — Medical Practice issues and alternative delivery systems

Reference Committee C (Ballroom D) — Legislation

Reference Committee D (Verelst Room) — Medical Education

Reference Committee F (Percival Room) — MAG's Budget

Reference Committee C&B (Vernon Room) — Constitution and Bylaws

### SECOND SESSION

Saturday, April 30

The Second Session of the House of Delegates will convene at 9:00 a.m. on Saturday, April 30 in the Ballroom.

Principal item of business will be consideration of reports submitted by the several Reference Committees. The Delegates' vote on each of the numerous resolutions and recommendations brought before the House will help establish MAG's official policies for the coming year.

Dr. Menendez, President, and MAG President-elect, Joseph P. Bailey, Jr., M.D. will address the House during the morning session. A special feature will be the address by our 1987 House of Delegates Keynote Speaker.

Election of officers nominated on Thursday evening will take place during the Saturday morning session. The Tellers will pass out, collect, and count the ballots, and the results will be announced before the lunch break. All newly elected officers will be installed during the afternoon session on Saturday.

### President's Reception

The MAG will honor our President, Dr. Jack F. Menendez, at a reception and dance 7:00-10:00 p.m., Saturday evening, in the Ballroom.

### Sunday, May 1

In the event that all Reference committee reports are not acted upon in Saturday's session, the House will be convened at 9:00 a.m., Sunday, in the Ballroom.



## *Schedule at a Glance...*

# MAG HOUSE OF DELEGATES

APRIL 28 — MAY 1, 1988  
HYATT REGENCY HOTEL  
SAVANNAH

### **THURSDAY, APRIL 28**

4:00-8:00 p.m. REGISTRATION (Ballroom Foyer)

7:00 p.m. GENERAL SESSION (Ballroom)  
Presiding: Jack F. Menendez, M.D.  
President

Opening Ceremonies  
Report of the President of the Auxiliary to the MAG,  
Mrs. Roy F. Vandiver  
Presentation of MAG Awards  
Recess

8:00-10:00 p.m. HOUSE OF DELEGATES, FIRST SESSION (Ballroom)  
Presiding: James A. Kaufmann, M.D., Speaker,  
and Jack A. Raines, M.D., Vice-speaker

Nominations for Association Officers and AMA  
Delegates or Alternates  
Introduction of New Business  
Recess

### **FRIDAY, APRIL 29**

7:30 a.m. REGISTRATION (Ballroom Foyer)

7:30 a.m. GaMPAC BREAKFAST (Ballroom)

9:00 a.m.-1:00 p.m. REFERENCE COMMITTEE HEARINGS  
(Ballroom D, E, F; Verelst, Percival & Vernon Rooms)

### **SATURDAY, APRIL 30**

8:30 a.m. REGISTRATION (Ballroom Foyer)

9:00 a.m.-5:00 p.m. HOUSE OF DELEGATES, SECOND SESSION  
(Ballroom)

Address of the President, Dr. Menendez  
Address of the President-elect, Dr. Bailey  
Report of Reference Committees  
Announcement of Election Results

7:00-10:00 p.m. PRESIDENT'S RECEPTION AND DANCE





# An outline of Georgia's *newest* physical rehabilitation center

## I. Palmyra Regional Rehabilitation Center

- A. Comprehensive rehabilitation
  - 1. Major physical and/or cognitive disabilities
  - 2. Inpatient *and* outpatient services
- B. Acute care hospital setting
  - 1. Modern 48-bed facility
  - 2. Located adjacent to HCA Palmyra Medical Centers
- C. Southwest Georgia's only inpatient rehabilitation facility

## II. Diagnoses treated

- A. Stroke and neurological diseases
- B. Spinal cord injury
- C. Head injury
- D. Arthritis
- E. Pediatric neuromuscular diseases
- F. Amputee
- G. Burns

## III. Services available

- A. Rehabilitative nursing
- B. Rehabilitative therapy
  - 1. Physical therapy
  - 2. Occupational therapy
  - 3. Speech and language pathology
  - 4. Therapeutic recreation
- C. Psychology
- D. Social work
- E. Vocational counseling
- F. Prosthetics and orthotics

## IV. Special procedures

- A. Nerve conduction studies
- B. Electromyography
- C. Evoked potentials

## V. Medical Director

- A. Board certified physiatrist
- B. Oversees medical and physical rehabilitation of all patients
- C. On campus office

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- B. Weekly team conferences
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# Auxiliary to the Medical Association of Georgia

## 63rd ANNUAL MEETING

DeSoto Hilton  
Savannah, Georgia

April 29-30, 1988



**“O**N BEHALF OF the Auxiliary to the Medical Association of Georgia, I am pleased to invite you to join me at the DeSoto Hilton Hotel, Savannah, Georgia, for the 63rd Annual Convention and meeting of the House of Delegates. Our theme: ‘Auxiliaries On The Move — Moving Expressly For Progress’ very aptly describes our actions this year. It is now time to ‘Move To Conclusion,’ to share and reward our many accomplishments and to conclude the business for the year.”

*Maureen T. Vandiver  
(Mrs. Roy W.)  
President, A-MAG*



**“I**T IS MY PLEASURE to welcome you to the Annual Convention of the Auxiliary to the Medical Association of Georgia at the DeSoto Hilton in historic Savannah.

The Auxiliary to the Georgia Medical Society (Savannah) is proud to be your host. We hope you will enjoy the meetings and special events that have been planned. Savannah is a lovely city in the springtime, and we look forward to sharing its charm and beauty with you.”

*Ann R. Purcell (Mrs. Dent W.)  
Convention Chairman, A-MAG  
(1987—1988)*



# AUXILIARY PROGRAM

## THURSDAY, APRIL 28

- 3:00-5:00 Registration and Information
- 7:00 Opening Session of the MAG House of Delegates
  - A-MAG President's Report: Mrs. Roy W. Vandiver
  - AMA-ERF Check Presentation

## FRIDAY, APRIL 29

- 9:00-5:00 Registration and Information  
Hospitality and Exhibits
- 10:00 PRE-CONVENTION EXECUTIVE BOARD MEETING  
(All former state presidents, state officers, state committee chairmen and members, county presidents and county presidents elect.)
- 12:00 AUXILIARY LUNCHEON  
(Executive Board, Delegates, MAG Committee on Auxiliary and guests.)  
  
Greetings from AMA-A  
Mrs. Anne Pitchford (W. Arnold),  
AMA-A Southern Regional Vice President
- 2:00 OPENING SESSION OF THE ANNUAL A-MAG HOUSE OF DELEGATES  
Call to Order  
Spotlighting County Presidents  
Opening Ceremonies  
President's Greetings  
Introductions  
Greetings from MAG President  
Special Address
- BUSINESS MEETING  
Introduction of Pages  
Credential Report  
Convention Standing Rules  
Adoption of Program  
Minutes  
Officers and Committee Reports  
Unfinished Business  
New Business  
Bylaws and Handbook Revisions  
Announcements  
Recess of Meeting
- EXHIBIT WALK  
County Exhibits, Scrapbooks, Doctor's Day, Medical Heritage (Research & Romance of Medicine)

- 6:30-7:30 AUXILIARY TO MAG PRESIDENT'S RECEPTION  
(Auxiliary Executive Board, MAG Committee on Auxiliary, Special Guests and all Auxiliary members.)

## SATURDAY, APRIL 30

- 9:00-12:00 Registration  
Hospitality and Exhibits
- 9:00 SECOND GENERAL SESSION HOUSE OF DELEGATES  
Introduction of Guests  
Introduction of Past Presidents  
Message from Southern Medical Association Auxiliary, Mrs. Joan Milburn (Graham) President, SMA-A Memorial Service
- Business Meeting (Continued)  
Revised Credentials Report  
Election of 1988-89 Nominating Committee  
Election of 1988 A-MAG Delegates for AMA-A Convention  
Report of Awards:  
Achievement, AMA-ERF, Brawner  
Certificates of Excellence, Doctor's Day, Membership, Safety, and Scrapbooks  
Report of 1987-88 Nominating Committee  
Election and Installation of Officers  
Presentation of 1988-89 President's Pin and Gavel  
Inaugural Address  
Presentation of Past President's Pin  
Announcements  
Adjournment
- 12:30 LUNCHEON  
(Newly installed state officers, outgoing officers, committee chairmen, committee members, county presidents, county presidents elect, nominated presidents-elect, delegates, alternate delegates, auxiliary members and guests.)
- POST CONVENTION EXECUTIVE BOARD MEETING
- PAST PRESIDENTS' LUNCHEON



# Kaposi's Sarcoma

Thomas W. Phillips, M.D.



**K**APOSI first described an "idiopathic, multiple, pigmented sarcoma," in Vienna in 1872. It was described as an isolated macule which will coalesce and cover a stocking distribution over the lower extremities. "This coalescent lesion will then spread to the viscera and over a varying interval, cause death in a certain number of patients."<sup>1</sup>

This sarcoma is found in North American people among Eastern European, Italian, and Ashkenasi Jewish extraction.<sup>2</sup> In equatorial Africa, it is common among the Bantu. In Tanzania, Kaposi's sarcoma in children mimics malignant lymphoma with nodal involvement, but the skin is spared; the reverse is true in adults.<sup>3</sup>

**S**chmid recognizes three different histologic types: granulomatous inflammation, predominantly angioblastic, and predominantly fibroblastic. There seems to be no prognostic difference related to histologic type, but there are differences in the course of the disease.

Five year's ago, Kaposi's sarcoma was a rarity, seldom seen.

*Dr. Phillips is Director, Radiation Oncology Department, Crawford W. Long Hospital. Send reprint requests to him at 25 Prescott St., Atlanta, GA 30365.*

*This paper was sponsored by the Georgia Division of the American Cancer Society. Those wishing to contribute papers to the CANCER Section should send them to Dr. Phillips, CANCER Section Editor, at the above address.*

Since the AIDS epidemic, however, this sarcoma has become fairly common. It is the presenting disease in about a third of AIDS patients.<sup>4</sup> The overall mortality in AIDS patients from Kaposi's sarcoma is approximately 40%. Classically, this presents in association with other malignancies, especially lymphomas.

There is no known treatment that offers much success. Single and multiple agent chemotherapy have been tried with variable results. Single agents which have been used include: nitrogen mustard, triazaquone, roxaxone, methotrexate, vinblastine, and vincristine. Drug combinations have included: dactinomycin, dacarbazine, vincristine, and alpha interferon. An alternative regimen of vinblastine and vincristine seems to offer the best results.<sup>5</sup> More complete responses have been reported in about 20% of the patients.

Radiation therapy is very useful for palliative purposes, with total disappearance of local lesions using low to moderate skin doses. Radiation as local surface treatment would obviously not affect the systemic component of the disease. There are reports of localized Kaposi's sarcoma not associated with AIDS which have apparently been eradicated permanently by radiation but, this

finding is virtually anecdotal. The distribution of Kaposi's in the skin of persons with AIDS seems to start in the classical pattern, i.e., with extremity lesions appearing first and secondary and tertiary lesions spreading to the trunk and head and neck. The lesions can be quite tender, ulcerate, and if on the plantar surfaces, confine the patient to bed. When the skin lesions coalesce and cover the extremities in stocking or glove fashion, the patient usually shows signs of visceral disease and soon succumbs.

## Summary

Kaposi's sarcoma, once rare, is now commonly seen in persons with AIDS. Although no definitive treatment is curative, the patient may be palliated with local radiation to skin lesions. Chemotherapy may be the only hope for cure, but in patients already compromised immunologically, chemotherapy is limited in usefulness.

## References

1. Francis ND. Kaposi's sarcoma in acquired immunodeficiency syndrome. *J Clin Path* 1986;39(5):469-74.
2. DiGiovanni JJ, Safai B. Kaposi's sarcoma — ninety cases. *Am J Med* 1981;71:779-83.
3. del Regato JA, Spjut HJ. *Cancer: Diagnosis, Treatment and Prognosis*. Mosby CV, Inc., 1970;5:194-5.
4. Safai B. Natural history of Kaposi's sarcoma in AIDS. *Ann Int Med* 1985;103(5):744-50.
5. Volberding PA. The role of chemotherapy for epidemic Kaposi's sarcoma. *Seminars Oncol* 1987;14(2):23-26.



## Physician Beware!

Paul Shanor

THE AIDS EPIDEMIC has brought new meaning to the Latin phrase, "Caveat Emptor," meaning "let the buyer beware." It can now read "Caveat Medicus," meaning "let the physician beware." As the primary health care provider the physician is caught between the proverbial rock (whether to protect the patient's right of privacy) and a hard place (whether to protect others from contracting the virus).

At first glance, it is obvious that the physician has foremost responsibility to the patient he or she is treating. The real dilemma occurs when the physician reasonably believes that the HIV-positive patient will not take the necessary precautions nor provide adequate disclosure when engaging in sexual activity with another person that would expose that person to the AIDS virus.

In *Tarasoff v Regents of the University of California*,<sup>1</sup> the California Supreme Court ruled that a health care provider (in this case, a psychologist) has a responsibility to a third party if there is a clear threat to that third party. In addition, though, the provider, when providing the warning, must know that he or she may be able to keep the danger from occurring.

The difficulty of *Tarasoff* is three-fold. First, it has not been accepted in all jurisdictions, including Georgia. Georgia courts

have not yet ruled that a health care provider has a greater responsibility to a third party than to the patient. Secondly, with respect to AIDS, it does not provide clear guidelines to a physician as to how to determine if a real threat exists. Finally, unlike *Tarasoff*, most activities in which the virus is spread are consensual.

At the same time, courts have ruled that non-disclosure that one has a contagious disease, even in a consensual relationship, is sufficient for a tort action. The case of *Kathleen K. v Robert B.*,<sup>2</sup> the man knew he had herpes and did not inform his partner. They had sexual intercourse, and Kathleen contracted herpes. She sued Robert for civil damages, and the court upheld her right to sue. Since AIDS is even more serious than herpes, it is possible that the courts would rule non-disclosed sexual activity violent enough behavior to force the physician to warn a third party under the *Tarasoff* reasoning.

AIDS presents the worst of both worlds — it is both contagious and deadly. Richard Belitsley, M.D., and Robert A. Solomon in *AIDS and the Law*, find that:

*Under either a contagious disease or a Tarasoff analysis, it is likely courts will find that physicians and therapists have a duty to inform their patients' known sexual partners if the*

*patient has AIDS. The accepted knowledge that AIDS is communicable through sexual intercourse, the possibility that exposure will lead to contracting the disease (even if only by a consensual sexual act), and the foreseeability of known sexual partners as "identifiable victims" fulfill the requirements necessary to overcome the presumption of confidentiality and establish a duty to disclose.*<sup>3</sup>

What this means is that the physician must trust his own judgment until the law clarifies the situation. If the Omnibus AIDS Bill before the Georgia General Assembly passes as currently written, it would provide that the physician may notify a spouse or sexual partner at risk, or may notify the Department of Human Resources of the names of the patient and any person(s) at risk. The physician would not be required to make any notification, but he or she would be protected from liability.

### References

1. *Tarasoff v Regents of the University of California*, 17 Cal. 3d 425, 551, p 2d 334, 131 Cal. Rptr. 14 (1976).
2. *Kathleen K. v Robert B.*, 150 Cal. App. 3d 992, 198 Cal. Rptr. 273 (1984).
3. Doctors and Patients: Responsibilities in a Confidential Relationship. In, *AIDS and the Law*. Burris, Scott, and Dalton, Harlon L., (eds). 1987, p 207.

Mr. Shanor is MAG's Legislative Counsel.



## *Should Children Be Included in Early Prevention Efforts Aimed at Reducing Coronary Heart Disease?*

*Sandra Hudson, M.D.*

### **Introduction**

**H**YPERCHOLESTEROLEMIA and its association with coronary heart disease has been a topic of considerable interest in recent years. Though numerous recommendations for screening and treatment for high cholesterol exist, specifically, the role of the pediatrician in this area is strongly debated. At issue is whether the recent literature supports early intervention in children, if it has been proven effective, and what is the best approach for treatment and screening. The NIH Consensus Committee reported in 1985 that, "It has been established beyond a reasonable doubt that lowering cholesterol (specifically LDL cholesterol) will reduce the risks of heart attacks caused by coronary heart disease."<sup>1</sup> The question remains; however, is this true in children? The specific influence of diet and other therapies in lowering cholesterol and

preventing coronary artery disease in children remains controversial. Recommendations by the American Heart Association (AHA), the NIH Consensus Conference and the American Academy of Pediatrics (AAP) are in conflict. The most conservative and skeptical group is the American Academy of Pediatrics. The following is a review of current controversial issues, including the reservations of the skeptics, supporting evidence cited by advocates, and available options for screening.

### **Those Opposed to Early Intervention**

**T**he AAP places considerable doubt on several theories which support taking an aggressive approach to intervention. A vast majority of the medical community feels that fatty streaks are the precursors of fibrous plaques and are associated with elevated cholesterol levels. These views are supported by pathologic studies by Holman, Strong and McGill in the 1950-1960s.<sup>2,3</sup> The AAP argues that the relationship of fatty streaks to fibrous plaques is a theory and remains uncertain.<sup>4</sup> For example, almost every child by age 10 has fatty streaks present in the aorta, regardless of race, sex, or environment.<sup>5</sup> Furthermore, the

majority of fatty streaks are found in the aortic ring region; however, most plaques are in the descending and abdominal aorta. It is known that fatty streaks in the coronary arteries parallel the development of plaques in the coronary arteries, but there is no proof that dietary measures will prevent atheromas from depositing on the intima of coronary arteries. The AAP also states that fibrous plaques do not have the same ubiquitous distribution among the world's populations as fatty streaks. In summary, "therefore there must be serious reservations about accepting the contention that fatty streaks in arterial vessels can be taken as evidence of the childhood origin of atherosclerosis due to limitations on current knowledge."<sup>4</sup>

Evidence that diet and drug intervention decreases cholesterol and the incidence of coronary artery disease is provided primarily by the landmark studies of the Lipid Research Clinic Coronary Prevention Trial.<sup>4,6-7</sup> This study was a double blind, multicenter, randomized trial in which approximately 4,000 asymptomatic middle-aged men (35-59) with primary hypercholesterolemia (levels >267 ug/dl) were divided into two groups. The treatment group was placed on a cholesterol

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This paper was sponsored by the Georgia Affiliate of the American Heart Association. Those wishing to contribute papers to this Section should send them to Dr. Wesley Covitz, HEART Section Editor, at the above address.



lowering diet and cholestyramine, a lipid lowering drug. The control group was placed on the same diet and a placebo. Results after 7 years revealed an 8.5% difference in reduction of cholesterol levels and a 19% difference in heart attacks and deaths related to coronary events.<sup>6,7</sup> The AAP feels too much emphasis is placed on these results and that broad conclusions are drawn. They point out that this study does not assess the effects of diet alone as a factor. Extreme caution should be used in extrapolating these results to other portions of the population specifically children. They summarize saying, "It doesn't appear that this study presents compelling evidence to alter diet in the first two decades of life."<sup>7</sup>

The number of deaths in the United States secondary to coronary artery disease has been decreasing since 1950.<sup>8</sup> This is supported by pathologic studies of Korean and Vietnam war soldiers in which the frequency of atherosclerosis decreased from 77 to 45%.<sup>4,9</sup> The skeptics admit that improved nutrition may be a factor but not specifically, reduced cholesterol.<sup>4</sup>

Concern has been raised that direct dietary measures may not support adequate growth and

development, especially during the adolescent growth spurt, at which time cholesterol levels fall anyway. In general, the AAP points out "that the physiologic and nutritional needs, especially during the adolescent growth spurt are different from those of adults, especially from those of middle-aged, sedentary men" who are at higher risk. They are afraid that proposed changes in diet may not provide high quality protein, iron, calcium, or essential minerals for growth.<sup>4</sup>

***“The AAP places considerable doubt on several theories which support taking an aggressive approach to intervention of children regarding coronary heart disease.”***

AAP representatives admit that published studies indicate that populations with a lower incidence of coronary artery disease have associated lower cholesterol levels in both children and adults and

that the dietary intake of cholesterol is less. Although the association of diet, serum cholesterol values, and coronary artery disease can be established in population studies, the AAP states that it is important to note that in American children a lack of correlation between diet and cardiovascular disease variables exist. Rather in childhood and adolescence, obesity, smoking and activity patterns are more important determinants of the likelihood of cardiovascular disease. They feel obesity, smoking, and activity patterns are established in the first 2 decades of life but argue against the proposed idea that adolescent eating behaviors persist into adulthood. Therefore, more efforts should be made in counselling concerning these factors which are strong risk factors. In general, they suggest working toward a prudent lifestyle rather than a prudent diet.<sup>4</sup>

Other nonsupporters are concerned that labeling children as being at risk for a future dire event may have a detrimental effect on emotional development.<sup>10</sup> Others argue that children ages 2-3 on low fat milk have an increased frequency of gastrointestinal illnesses.<sup>11</sup> In addition, in a few adult studies, diets with high intake of polyunsaturated fats have been



associated with an increased incidence of gallstones and some cancer deaths.<sup>12, 13</sup>

#### Those in Favor

**P**roponents for early intervention argue that despite the decline in coronary heart disease, it continues to be the most common cause of premature death and disability in the United States, with the greatest impact on individuals in the most productive years of their lives, the years in which they have their greatest responsibility to family and community. They state that coronary artery disease causes 550,000 deaths a year, many of them sudden, thus we need to intervene to prevent the underlying process.<sup>1</sup>

They admit that the specific influence of diet in decreasing cholesterol levels and preventing coronary artery disease in children is still controversial, mainly because interpretation of various studies is subject to the perspective or bias of the interpreter. However, the amount of circumstantial evidence supporting intervention is substantial, and proponents feel that although the atherosclerosis theory is not foolproof, children with an increased percent of fatty streaks do have increased levels of cholesterol.<sup>13, 14</sup> They also acknowledge the decreasing incidence of coronary artery disease but point out that 45% of young soldiers still have atherosclerotic plaques<sup>13</sup> — plaques that had to develop in childhood; therefore, intervention at this time is necessary.

#### Studies Cited

Epidemiologic studies, such as the Framingham Studies, support the fact that cholesterol levels are a strong risk factor for coronary artery disease.<sup>1, 15</sup>

Retrospective studies of victims of coronary deaths, especially younger victims, have revealed an increased prevalence of hypercholesterolemia, and relatives of these victims have higher cholesterol levels and increased risk of coronary heart disease. The reverse has also been shown to be true.<sup>13, 16, 17</sup>

Cross cultural studies show that Westernized cultures have an increased incidence of coronary heart disease, which positively correlates with increased dietary intake of saturated fats and cholesterol.<sup>13, 15</sup>

Animal models, including primates, have developed atherosclerotic lesions on diets resembling the American table diet, and these lesions regress with dietary modifications involving lowering cholesterol levels.<sup>1, 18</sup>

Pathophysiologic studies reveal that the major lipid component of the atherosclerotic plaque which is already present in 18 year olds is a lipoprotein of cholesterol, specifically LDL.<sup>13, 15</sup>

Genetic studies have shown that children with familial hypercholesterolemia who have decreased LDL receptors, which are important in decreasing serum cholesterol, have increased LDL levels (the atherogenic cholesterol component). It has been clearly demonstrated that the accelerated

and clinically catastrophic coronary related events, including premature deaths, in these children results from their high blood cholesterol levels.<sup>1, 13</sup>

In addition, "regression of coronary artery and aortic atherosclerotic lesions has been reported after lowering plasma cholesterol with the portacaval shunt procedure in children."<sup>13</sup> It is felt that decreasing cholesterol by diet should accomplish the same thing.

**“Proponents feel that although the atherosclerosis theory is not foolproof, children with an increased percent of fatty streaks do have increased levels of cholesterol.”**

Studies have shown that plasma levels of cholesterol and lipoproteins do track significantly. Therefore, extrapolating data from adult studies is reasonable.<sup>1, 13</sup> Limited diet studies comparing children on formula preparations low in saturated fats reveals no significant difference in growth with those that have been breast fed; so, modified diets even in infancy appear to be safe.<sup>19</sup> Proponents for early intervention in general, including the AAP, support intervention in all risk factors especially obesity, exercise, and smoking.<sup>1, 20</sup>



In summary, as one advocate put it, "what if, after a nationwide preventive cardiology program for children, we learn in 25-50 years from now that coronary heart disease is not being minimized or prevented? We have simply increased the number of individuals in the nation who eat sensibly, are not obese, and remain physically active throughout life and who have avoided the offensive and dangerous habit of smoking."<sup>21</sup>

### Options for Intervention

Four options for intervention have been proposed depending upon where one stands in this controversy:

**1** *The first approach is not to intervene at all.* This is supported by the fact that the incidence of coronary heart disease is decreasing already, so why intervene with measures that have not been proven to be effective in children and may, in fact, be detrimental to their physical and emotional development. In addition, the optimal method of screening has not yet been determined, so its difficult to propose an optimal plan.<sup>4, 21</sup>

**2** *The second approach is to recommend a prudent diet for the entire population.* The argument for this approach is based on the fact that the U.S. has an increased incidence of coronary artery disease associated with an increased level of cholesterol in comparison with other populations with lower coronary artery disease and cholesterol. Our average

cholesterol level is too high. Therefore, by decreasing the cholesterol level on a population basis we can then shift the entire population curve to the left and hopefully decrease the incidence of coronary artery disease.

The problem with this approach is in defining the best "prudent diet." Currently, the AHA and the AAP differ primarily in the emphasis placed on total dietary fat, saturated fat, the ratio of polyunsaturated/saturated fat, and the age of intervention.<sup>1, 4, 20</sup> The AAP's concern is whether limiting fat intake to 30% as recommended by the AHA will provide adequate calories for growth. Secondly, an extreme decrease in saturated fat compared to polyunsaturated fat is associated with decreased HDL levels which are thought to be protective against coronary artery disease.<sup>4</sup> In general, all recommend a prudent diet for children >2 years, with emphasis on decreased total and saturated fat intake with moderation. In addition, one should stress the importance of a healthy diet rather than just listing what one should not eat.

**3** *The third approach is universal screening.* Supporters for routine screening note that a high risk approach will miss some children with increased cholesterol. For example, one patient screening factor is a family history of increased cholesterol. Many adults do not know their own cholesterol level, and many children are from single parent families in which the family history of the other parent is unknown.<sup>22</sup>

**4** *The fourth approach is high risk screening* which is supported by the AAP, NIH, and AHA and appears to be the most practical approach.<sup>1, 4, 20, 22</sup> Screening includes fasting cholesterol, HDL, triglyceride levels and calculated LDL. If LDL or cholesterol levels are >75 percentile, they should be repeated on 1-2 occasions. If they continue to be >75-90th percentile for cholesterol (170-185) or LDL or (110-125), secondary causes such as drugs (especially steroids) or diseases (such as diabetes, hypothyroidism or nephrosis) should be ruled out, and the patient should be placed on a prudent diet.<sup>1</sup>

**“Concern has been raised that direct dietary measures may not support adequate growth and development, especially during the adolescent growth spurt, at which time cholesterol levels fall anyway.”**

After 6-12 months, repeat the blood work. If the elevated levels persist, stricter dietary measures should be used, such as AHA phase diets which place increasing restrictions on total and saturated fats.<sup>1</sup>



Children with cholesterol levels >90th percentile are considered at high risk. Familial hyperlipidemias should be ruled out with electrophoresis and ultracentrifugation methods. Family members should be screened. They should be placed on diets as previously indicated. If there is no improvement, medication should be considered.<sup>1</sup>

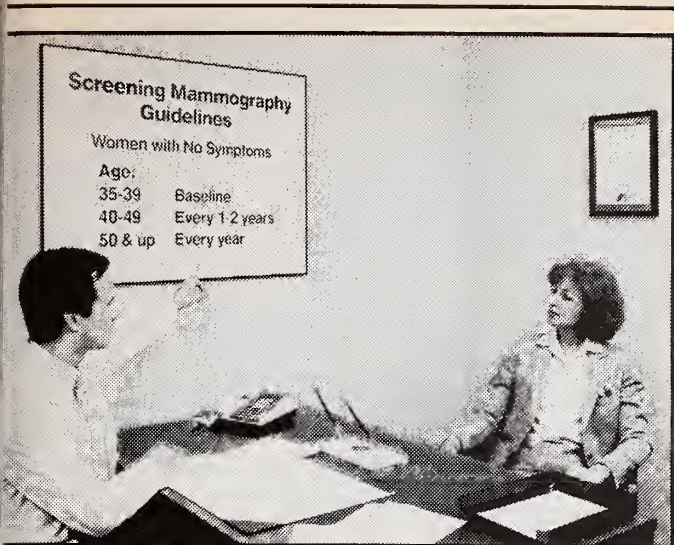
### Summary

There are multiple risk factors for atherosclerosis and coronary heart disease including obesity, smoking, exercise, and increased cholesterol. This discussion was focused on the role of lipids. Coronary heart disease is still a major cause of death in the U.S. Further studies need to be done to prove cause and effect especially in children. However, a definitive long-term study over 40-50 years may not be feasible. There is enough evidence to support the theory that atherosclerosis begins in childhood. Therefore, we should take advantage of our unique opportunity to intervene in hopes of prevention.

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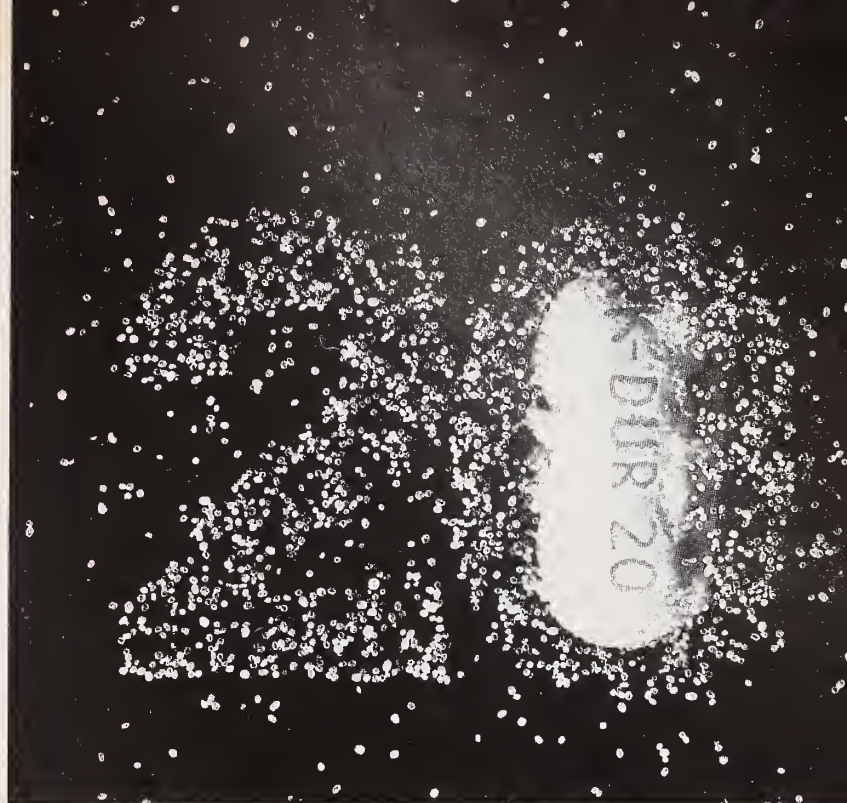


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1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis, in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.
2. For the prevention of potassium depletion when the dietary intake is inadequate in the following conditions: Patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, and with certain diarrheal states.
3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

**CONTRAINDICATIONS:** Potassium supplements are contraindicated in patients with hyperkalemia since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: Chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene).

Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to enlarged left atrium.

All solid dosage forms of potassium chloride supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation.

**WARNINGS: Hyperkalemia**—In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic. The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

**Interaction with Potassium-Sparing Diuretics**—Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene) since the simultaneous administration of these agents can produce severe hyperkalemia.

**Gastrointestinal Lesions**—Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage or perforation.

K-DUR tablets contain micro-crystalloids which disperse upon disintegration of the tablet. These micro-crystalloids are formulated to provide a controlled release of potassium chloride. The dispersibility of the micro-crystalloids and the controlled release of ions from them are intended to minimize the possibility of a high local concentration near the gastrointestinal mucosa and the ability of the KCl to cause stenosis or ulceration. Other means of accomplishing this (e.g., incorporation of potassium chloride into a wax matrix) have reduced the frequency of such lesions to less than one per 100,000 patient years (compared to 40–50 per 100,000 patient years with enteric-coated potassium chloride) but have not eliminated them. The frequency of GI lesions with K-DUR tablets is, at present, unknown. K-DUR tablets should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

**Metabolic Acidosis**—Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, potassium acetate, or potassium gluconate.

**PRECAUTIONS:** The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis per se can produce hypokalemia in the absence of a deficit in total body potassium while acute acidosis per se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium. The treatment of potassium depletion, particularly in the presence of cardiac disease, renal disease, or acidosis requires careful attention to acid-base balance and appropriate monitoring of serum electrolytes, the electrocardiogram, and the clinical status of the patient.

**Laboratory Tests:** Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

**Drug Interactions:** Potassium-sparing diuretics; see **WARNINGS**.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** Long-term carcinogenicity studies in animals have not been performed.

**Pregnancy Category C:** Animal reproduction studies have not been conducted with K-DUR. It is also not known whether K-DUR can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. K-DUR should be given to a pregnant woman only if clearly needed.

**Nursing Mothers:** The normal potassium ion content of human milk is about 13 mEq per liter. Since oral potassium becomes part of the body potassium pool, so long as body potassium is not excessive, the contribution of potassium chloride supplementation should have little or no effect on the level in human milk.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS:** One of the most severe adverse effects is hyperkalemia (see **CONTRAINDICATIONS**, **WARNINGS**, and **OVERDOSAGE**). There have also been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see **CONTRAINDICATIONS** and **WARNINGS**); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

**OVERDOSAGE:** The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see **CONTRAINDICATIONS** and **WARNINGS**). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration and characteristic electrocardiographic changes (peaking of T-waves, loss of P-waves, depression of S-T segment, and prolongation of the QT-interval). Late manifestations include muscle-paralysis and cardiovascular collapse from cardiac arrest.

Treatment measures for hyperkalemia include the following:

1. Elimination of foods and medications containing potassium and of potassium-sparing diuretics.
2. Intravenous administration of 300 to 500 ml/hr of 10% dextrose solution containing 10–20 units of insulin per 1,000 ml.
3. Correction of acidosis, if present, with intravenous sodium bicarbonate.
4. Use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia, it should be recalled that in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

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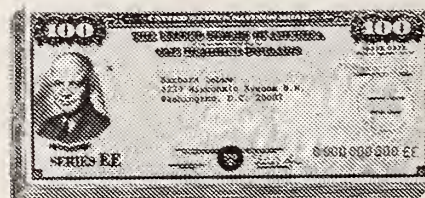
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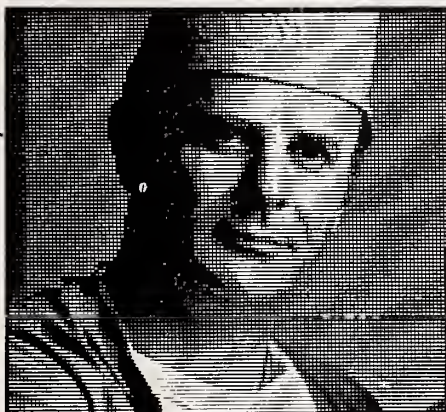
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# ADDENDUM TO:

Since the distribution of MAG's 1987-88 *Roster* of Association members last August, we have become aware that a number of MAG members in good standing were inadvertently omitted. We apologize for this oversight and herewith publish both their names as well as those who have joined the Association since publication of the *Roster*. You may wish to detach these pages and insert them into your copy of MAG's 1987-88 *Roster*.

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35 COLLIER RD NW, ATLANTA 30309		35 COLLIER RD NW STE 675, ATLANTA 30309		2432 PARKWOOD DR, BRUNSWICK 31520	
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3280 HOWELL MILL RD NW 201, ATLANTA 30327		1359 MILSTEAD RD, CONYERS 30207		PO BOX 1968, HINESVILLE 31313	
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<b>HURST, J. WILLIS</b>	29 ACT IM	<b>PEACOCK, LAMAR B.</b>	29 ACT IM	<b>SMITH, JOSEPH R.</b>	54 I&R NS
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<b>JOLLY, PRADEEP C.</b>	29 ACT IM,HEM	<b>POOLE, ROBERT NEIL</b>	29 ACT PD	<b>STEINHAUS, JOHN E.</b>	29 ACT AN
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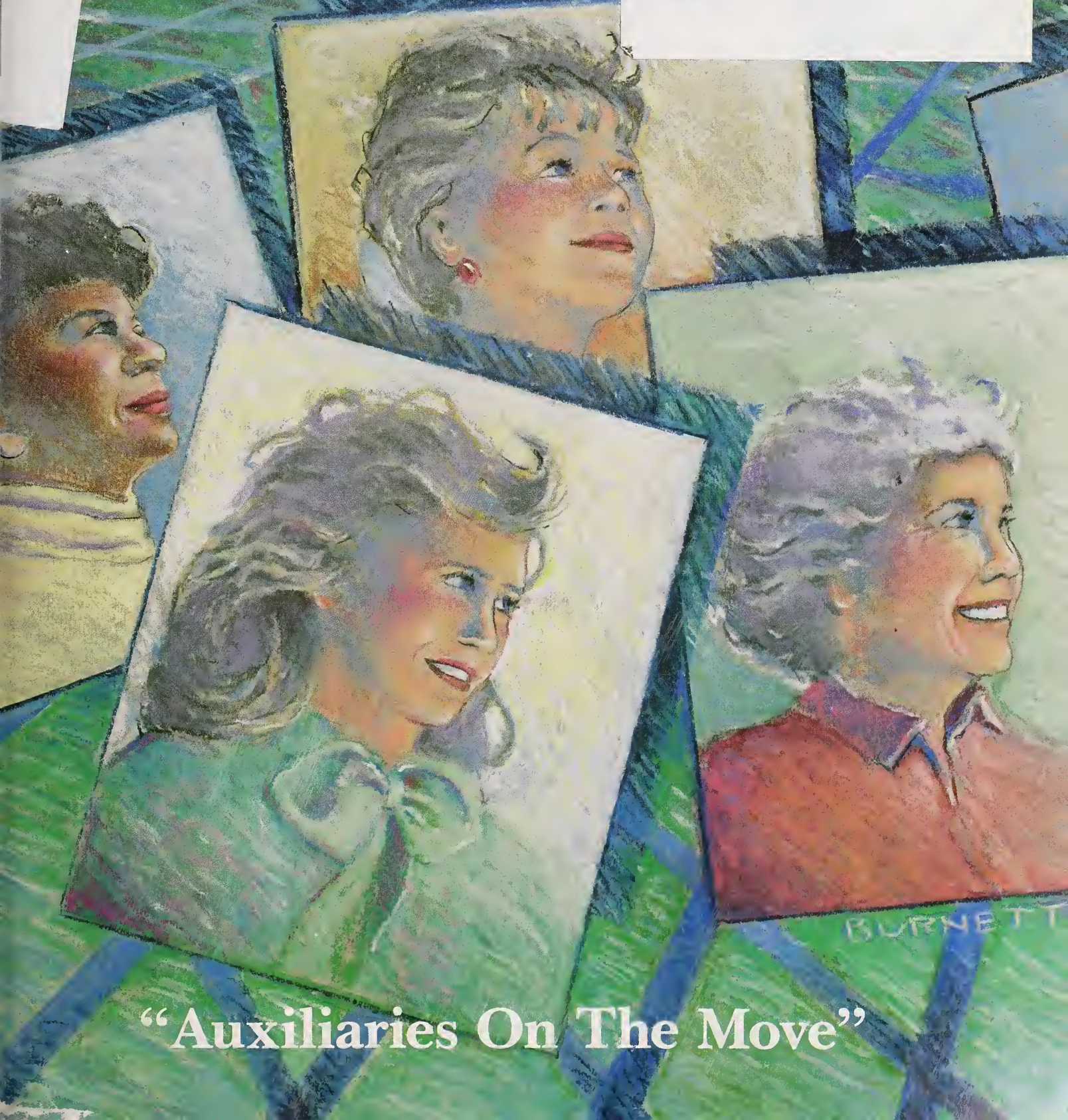


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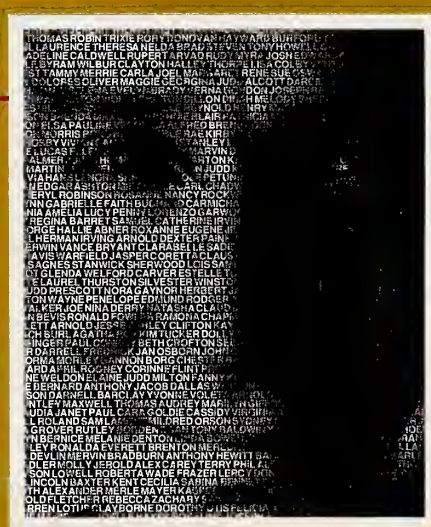
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# ON

...like the more than one million patients who have received **INDERAL® LA**.

In a recent survey, 4,120 participating physicians gave us their views<sup>1</sup> on **INDERAL LA** in the treatment of hypertension, angina and migraine.

## **INDERAL LA is their preferred beta blocker**

...of the nearly three out of four physicians responding to the questionnaire, an impressive 97% rated **INDERAL LA** good to excellent for overall performance. Virtually all cited efficacy, tolerability, long-term cardiovascular protection and once-daily convenience as important factors in their choosing to prescribe **INDERAL LA**.

## **INDERAL LA promotes patient compliance**

...Virtually every responding physician rated patient satisfaction with **INDERAL LA** to be as good as, or better than, other beta blockers.

Like conventional **INDERAL** Tablets, **INDERAL LA** should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree and bronchial asthma.

**ONCE-DAILY**  
**INDERAL® LA**  
 (PROPRANOLOL HCl) **LONG ACTING CAPSULES**  
 60, 80, 120, 160 mg

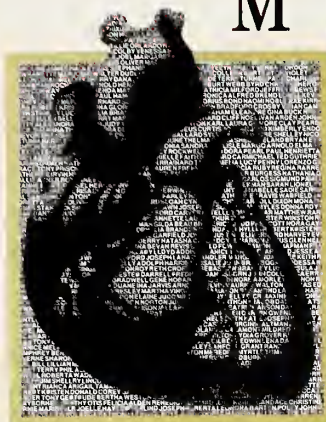
# The one you know best keeps looking better

Please see next page for brief summary of prescribing information.

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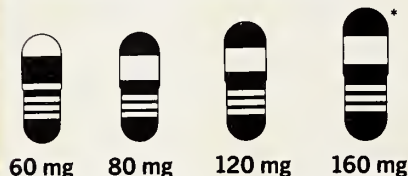


Feel Like a  
MILLION



ONCE-DAILY  
**INDERAL<sup>®</sup> LA**  
(PROPRANOLOL HCl)  
LONG ACTING CAPSULES  
60, 80, 120, 160 mg

The one you know best  
keeps looking better



BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

**INDERAL<sup>®</sup> LA** brand of propranolol hydrochloride (Long Acting Capsules)

**DESCRIPTION.** INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

**CLINICAL PHARMACOLOGY.** INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure, and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

**INDICATIONS AND USAGE.** **Hypertension:** INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

**Angina Pectoris Due to Coronary Atherosclerosis:** INDERAL LA is indicated for the long-term management of patients with angina pectoris.

**Migraine:** INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

**Hypertrophic Subaortic Stenosis:** INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

**CONTRAINDICATIONS.** INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

**WARNINGS.** **CARDIAC FAILURE:** Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

**IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE,** continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

**IN PATIENTS WITH ANGINA PECTORIS,** there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it is usually advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

**Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS.** INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

**MAJOR SURGERY:** The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

**DIABETES AND HYPOGLYCEMIA:** Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

**THYROTOXICOSIS:** Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T<sub>4</sub> and reverse T<sub>3</sub>, and decreasing T<sub>3</sub>.

**IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME,** several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

**PRECAUTIONS.** **GENERAL:** Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

**CLINICAL LABORATORY TESTS:** Elevated blood urea levels in patients with severe heart disease elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

**DRUG INTERACTIONS:** Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL (propranolol HCl) is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncope attacks or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure, or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenyltoin, phenobarbitone, and rifampin accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and lidocaine have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T<sub>3</sub> concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

**CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY:** Long-term studies in animal have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

**PREGNANCY:** Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**NURSING MOTHERS:** INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

**PEDIATRIC USE:** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS.** Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

**Cardiovascular:** Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

**Central Nervous System:** Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dream appear dose related.

**Gastrointestinal:** Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

**Allergic:** Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

**Respiratory:** Bronchospasm.

**Hematologic:** Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

**Auto-immune:** In extremely rare instances, systemic lupus erythematosus has been reported.

**Miscellaneous:** Alopecia, LE-like reactions, psoriasisiform rashes, dry eyes, male impotence, Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

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**Reference:**

1. Data on file, Ayerst Laboratories.

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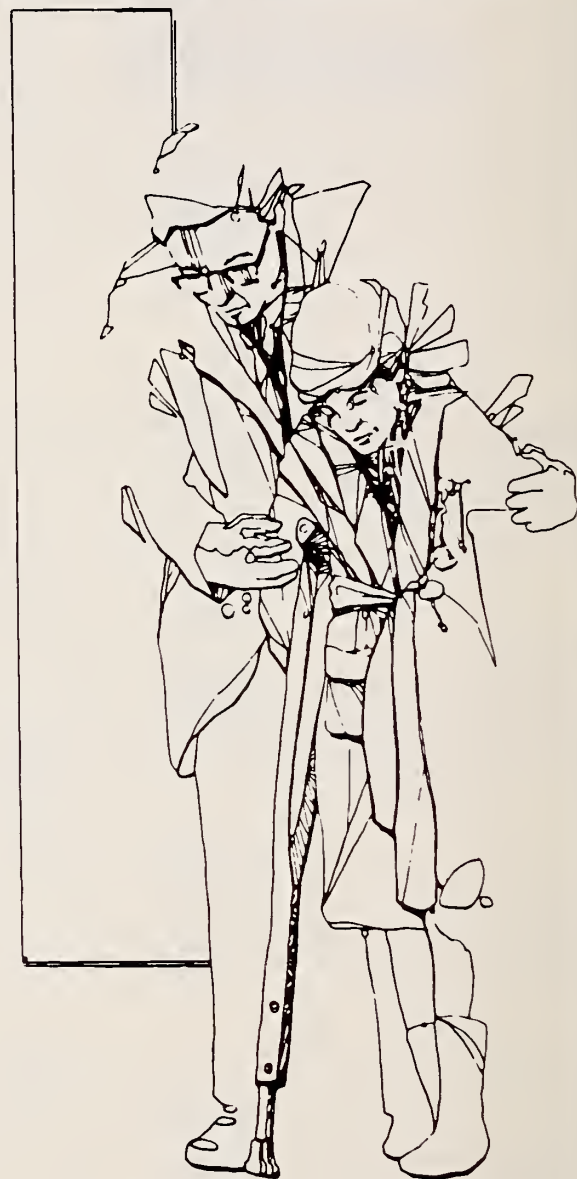
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**COVER**

Artwork by Lindy Burnett, of Atlanta.



## *The Helga Paintings*

**“Why do you not have difficulty looking at the Sistine Chapel when you know that Rembrandt had a mistress? ‘Because Rembrandt did not paint the Sistine Chapel,’ she said.”**

**W**E WERE HAVING LUNCH at Maison Robert in Boston, my traveling companion and I, when I remarked, “We must see the Helga paintings at the Museum of Fine Arts.”

Boston, of course, is full of fine eating establishments, but this has to be one of the best. It is located in the old City Hall building and has survived for several years, attesting in some degree to its quality. The places on the wharves are always there but usually too congested for one’s contemplative comfort during the meal. The nutritional nourishing of one’s body is a many-faceted affair. Some engage in the activity out of necessity, casting not so much as a curious glance at the ingested morsels, while others gaze with religious rapture at the visual presentation of the food upon platters, simultaneously and ecstatically exposing their olfactory organs to the aroma arising from it. One must not expend the monetary outlay required at Maison Robert unless some slight tendency to the latter two proclivities be present in their gastronomical nature.

But then, about the Museum and the paintings. “No,” she said with that kind of definitiveness which, though not too often exhibited, carries with it clear and unmistakable meaning when it does surface. She went on to say that the things Andrew Wyeth had

done prior to “The Helga Paintings” had for her always been meaningful and admirable. But, she said, the way the Helga paintings had been presented to the public had changed it all. The “P.R. aspect” of the thing had created the alteration in outlook and indeed the ability to appreciate other works. I had thought the secretive manner of doing these many intimate portrayals of a supposedly carefully hidden mistress carried with it an aura of stimulative mysticism. But, she went on to tell me, that the wife had known about the project all the time and that the implication of secretly done paintings not known to the wife had been used as a method of creating a marketplace interest that would otherwise not have existed. My traveling companion seemed to have come into possession of information that had eluded me.

And then she said, “Why did he do it? He really didn’t need the publicity — the whole thing changed my opinion of him. I really can’t look at his other pictures as I used to.” She went on to elaborate that she had no less regard for his talent as an artist and yet less regard for him as an individual. And so I asked her, “You seem to attach so much importance to his extracurricular, his extramarital affairs, and let them interfere with his talent as an



artist. Why do you not have difficulty looking at the Sistine Chapel when you know that Rembrandt had a mistress?"

"Because Rembrandt did not paint the Sistine Chapel," she said.

I tried again, "Well, then, Leonardo? Forget my poor memory. I only wonder if knowing of the affairs of such people interferes with your appreciation of their art?" She went on to say that indeed it did not, for they had not used such relationships to in any way further the success of their professional endeavors.

Well, the conversation ended somewhere thereafter. Needless to say that other activities replaced the visit to The Museum. Helga still lies nude upon her simple bed without the benefit of our passing judgment on the sophistication of the artist or the accurate rendering of the anatomical features of the female body.

I had, many years before, seen a play done by the Alliance Theater in Atlanta which they called, "The Night Thoreau Spent in Jail." I had long remembered one particular scene, and line, in that theatrical endeavor. It took place when the two close friends, Ralph Waldo Emerson and Henry David Thoreau, were discussing the loss of their friendship. Thoreau had been jailed for standing on principle which itself conflicted with the law of the land. Emerson,

on the other hand, had compromised. And so, when queried as to the cause of the rift in the relationship, Thoreau had responded to his friend, "It was because I thought so much of you, that I expected so much more from you."

I find myself worrying on occasion over what they say has happened to the reputation of the medical profession. They say we are brought into question more than we used to be, our intentions suspect, our basic interests centered more on personal gain and security than on patient welfare. That attitude of the public did not seem to exist 100 years ago — or 50 or even perhaps 20 years ago. But have we really changed? Is it not more a matter of the physicians of an earlier era being granted prestige and position and trust not truly deserved by the entire cadre of physicians? Is it not merely that we are being asked to be more openly and understandably ourselves? Could it be that we are simply being asked when we paint pictures of nude women that we do so with fair and honest representation of the events surrounding that artistic undertaking? ■

CRU



## GHA Goes to Washington

**G**HA STAFF AND REPRESENTATIVES from 19 Georgia hospitals met recently with the state's congressional delegation in Washington, DC.

The group presented the issues facing hospitals and gave the following recommendations for solutions:

- Medicare payments — increase hospitals' Medicare rates by the same percentage as the marketbasket increases.

- Medicaid rates — eliminate the current system that ties Medicaid increases to the rate of increase in Medicare payments.

- Rural hospitals — make rural hospitals' Medicare payments comparable to those of urban hospitals.

- Indigent care — provide a minimum health insurance requirement for employers, state risk pools for the medically uninsurable, and tax incentives for self-employed persons to purchase insurance.

- Nursing — fund a national manpower data system and demonstration projects to study nurse retention.

- Medicare mortality data — withhold publication of Medicare mortality data until other measures of quality are identified.

- Appeal rights for providers — provide review of peer review organization decisions before sanctions can be imposed on hospitals or physicians.

- PRO contracts — require PROs to increase review of hospitals that have utilization or quality problems and decrease review of hospitals having no such problems.

- AIDS — provide funding for AIDS research and education and for hospital care of AIDS patients.

## Hospital Medicare Payments

**T**HE GOVERNMENT AGAIN has its eye on hospitals' Medicare payments, this time looking to cut another \$1.26 billion from next year's Medicare spending. The Health Care Financing Administration estimates that the biggest cuts — \$920 million — would be taken out of hospitals' indirect graduate medical education payments.

The government's plan would also take \$413 million out of Medicaid. Funds for AIDS treatment, however, would increase from 1988's \$375 million to \$600 million next year. Total spending for AIDS education, research, and treatment would see a 40% increase to \$2 billion.

## AIDS and Employers

**A** SURVEY by a New Jersey company shows that AIDS may now affect as many as 10% of the nation's employers.

The survey, which covered 2,000 employers, also found that only about 1% of employers test job applicants for the virus. Surveyors were Alexander & Alexander Consulting Group Inc in Lyndhurst.

## Mandated Health Care Coverage Proposed

**T**HE SENATE LABOR AND HUMAN RESOURCES Committee has approved a measure that would mandate health care coverage for most employees. The bill would require employers to provide coverage for every employee who works 17.5 or more hours a week. That coverage would include the following:

- catastrophic protection after the employee incurs \$3,000 in out-of-pocket expenses,

- a 20% limit on employee copayments, and

- 45 days of inpatient care for mental disorders and 20 days of outpatient counseling.

Employers would be required to pay 100% of the premiums for low-income workers.

The bill is expected to meet tough opposition in the Senate. Orrin G. Hatch (R-UT), ranking minority member of the Labor and Human Resources Committee, has termed it "socialism, pure and simple."

## Hospital Smoking Ban 90% Effective

**S**MOKING IS ON ITS WAY out of the hospital. The American College of Healthcare Executives reports that 90% of hospitals now have smoking restrictions, most limiting smoking to certain areas. Another 6% are considering smoking policies.

Most hospitals, says the Chicago based organization, believe they have a "moral responsibility" as health care organizations to limit smoking.

About 8% of hospitals ban smoking entirely, with the exception that patients can smoke with their physicians' permission.



## *Auxiliaries on the Move*

**H**AVE YOU and your family noticed some changes in your life? Have you missed your auxiliary spouse this year? Have you eaten a lot of leftovers or enjoyed hamburgers and pizza more often than usual? Can you write "dust me" on the coffee table? Is the ironing basket filled most of the time with those shirts and clothes that used to hang freshly ironed in your closet? If you have answered "yes" to any of these questions, you are married to a very busy auxiliary member. Be of good cheer, because all is not lost! Although your diet and your appearance may be showing signs of neglect, the image of the physician's family is being enhanced in the community. "How can that be?" you may ask.

**"A**uxiliaries on the Move — Moving Expressly For Progress" has been our theme for the auxiliary this year. Our members have been busy working in coalitions with their medical societies, "moving" into their communities with programs on Teen Pregnancy, Seat Belt Safety, Teen Suicide, Child Abuse, AIDS Education, and Substance Abuse, to name only a few. Working in tandem with our medical societies in our local communities to improve the health and quality of life sends an important message that we do care and we are concerned.

It is our goal to inform you in this issue of the *Journal of the Medical Association of Georgia* about the health projects and programs which we have been involved in this year. Please read, enjoy, and the next time you greet an auxiliary member say, "Thank You."

*Maureen Vandiver (Mrs. Roy W.)  
President, Auxiliary to the MAG*



## NEW MEMBERS

- Barlow, James C., Gastroenterology — Spalding — 231 Graefe St., Griffin 30223
- Bilodeau, Paul A., Internal Med. — Richmond — 3482 Stallings Island Rd., Martinez 30907
- Brende, Joel O., Psychiatry — Muscogee — 2000-16th Ave., Columbus 30307
- Cardenas, Francisco J., Gastroenterology/Internal Med. — Cobb — 1001 Thornton Rd., Lithia Springs 30057
- Chang, Shi-Chieh, Family Practice — Laurens — 111 West Court St., Wrightsville 31906
- Chaudhury, Tarun K., Internal Med. — Muscogee — 3929 Armour Ave., Apt. D-29, Columbus 31904
- Cheek, Jonathan A., Pediatrics — Cherokee-Pickens — P.O. Box 1269, Canton 30114
- Cheloliber, Victor V., Internal Med. Gwinnett-Forsyth — 2000 Northeast Expressway, Norcross 30071
- Clanton, Douglas W., Orthopaedic Surgery — Cherokee-Pickens — 120 Waleska Rd., Canton 30114
- Clifton, Joe C. — Bibb — 1800 Wesleyan Dr., #32, Macon 31210
- Corse, Steven K., — Internal Med. — Cobb — 106 South Main St., Ste. C, Woodstock 30188
- Faulk, David J. — Bibb — 4082 West Oak Dr., Macon 31210
- Field, Richard S., Internal Med./Rheumatology — Richmond — Dept. of Med. Medical College of Georgia, Augusta 30912
- Fowler, Raymond L., Emergency Med. — Douglas — 9280 Highway 5, Ste. E, Douglasville 30134
- Glass, Frederic C., Occupational Med./E, Emergency Med. — MAA — 4682 Stonehenge Dr., Doraville 30360
- Grooms, James D., Dermatology — Glynn — 3116 Shrine Rd., Brunswick, 31520
- Guy, Daniel K., Orthopaedic Surgery — Troup — 301 Medical Dr., La Grange 30240
- Hill, Debra Lynn, Obstetrics/Gynecology — MAA — 1739 Woodcliff Ct., Atlanta 30329
- Hodges, Wayne, Pain Med./Psychosomatic Med. — Georgia Medical — 340 Eisenhower Dr., 1480 Central Pk., Savannah 31406
- Hudgins, Roger J., Neurosurgery — MAA — 5555 Peachtree Dunwoody Rd., Atlanta 30342
- Jarman, Robert H., Anesthesiology — Georgia Medical — 515 East 63rd St., Savannah 31405
- Johnson, Sidney P., General Practice — Altamaha — 101 Old Alma Rd., Hazlehurst 31539
- Kinstler, Michael J., Internal Med., — DeKalb — 2193 North Decatur Rd., Decatur 30033
- LaRue, Todd G., Family Practice — Bibb — 575 Rogers Dr., Macon 31204
- Linkous, Harry A. III, Family Practice — Bibb — 761 Winchester Cir., Macon 31210
- McMahan, Howard A., Orthopaedic Surgery — MAA — 35 Collier Rd., Ste. 520, Atlanta 30367
- Meyer, Kenneth E., Diagnostic Radiology/Nuclear Med. — Cobb — 1096 Sheridan Pk., Atlanta 30324
- Middlebrooks, Tracy W. Jr., Pediatrics — Richmond — 1021 15th St., Ste. 8, Augusta 30901
- Miller, Conrad N. Jr. — Bibb — 1810 Winship St., Apt. 1, Macon 31204
- Nieves, Rafael A., Pediatrics — Clayton-Fayette — 6584 Professional Place, C Riverdale 30296
- Parsons, Gregory S., Otolaryngology — Floyd-Polk-Chattooga — 27 Saddle Mountain Rd., Rome 30161
- Petry, L. Jeannine, Family Practice — Richmond — Dept. F Family Med., EG-203, Medical College of Georgia, Augusta 30912
- Pittari, John J., Radiology/Nuclear Med. — Decatur-Seminole — Memorial Hospital Radiology Dept., 1500 East Shotwell St., Bainbridge 31717
- Roig, Armando V., Orthopaedic Surgery — Baldwin — 811 North Cobb St., Milledgeville 31061
- Simmons, Deborah A., Anesthesiology — Troup — 206 Waverly Way, La Grange 30240
- Stulberger, Abraham, Internal Med. — Richmond — 3623 J. Dewey Gray Cir., Augusta 30909
- Smith, Harold E., Addictionology — Cobb — 3995 South Cobb Dr., Smyrna 30080
- Techman, Therese M., Substance Abuse/Ambulatory Med. — MAA — 4130 Mountain Oak Cove, Stone Mountain 30083
- Thomson, Norman B. III, Radiology — Georgia Medical — 5223 Paulsen St., Savannah 31405
- Whiteley, Andre B., Radiation Oncology — MAA — 4235 Paces Ferry Rd., Atlanta 30339



## SOCIETIES

### *DeKalb County Medical Society*

**A**t the recent Annual Meeting of the DeKalb Medical Society, Decatur Federal Savings and Loan Association presented the coveted Julius McCurdy Citizenship Award to Tucker dermatologist, Don W. Printz, M.D., in recognition of his extraordinary service to his community and his profession.

For the past 4 years, Dr. Printz has served as staff physician for the Techwood Baptist Center, located in the Techwood Housing Project. At the Techwood Project, he operates a clinic along with several other physicians, seeing patients who are unable to go to Grady or other county health facilities to receive medical care.

He has also been active with the Street Ministry Program of the First Baptist Church of Atlanta, providing not only medical care but also assisting the preparation of evening meals and with the counseling of this neglected segment of our population.

Dr. Printz initiated a treatment facility at the Fulton County Health Department to identify and treat indigent patients with sexually transmitted diseases, using his expertise as the former Clinical Research Chief of the Sexually Transmitted Disease Branch of CDC. Not only did he establish this facility, he served as the primary staff physician during its initial period of operation, donating his time and talents twice weekly.

Dr. Printz has also been extremely active with the Northlake



**Chuck Warren** (L), Vice President of Decatur Federal Savings and Loan Association, presents the coveted Julius McCurdy Citizenship Award to **Dr. Don Printz**.



*DeKalb Medical Society Officers for 1988 are (L-R) **Dr. Gary Botstein**, Secretary-Treasurer; **Dr. Bill Whitaker**, President-Elect; **Dr. Bill Keeton**, President; and **Dr. Walker Ray**, Vice President.*



Rotary Club, serving on numerous committees and in all of the offices, including the office of President in 1981. He is also the Immediate Past President of the Southeastern Dermatology Association.

## *Muscogee County Medical Society*

**“A**IDS: FIGHTING FEAR WITH FACTS” was held in Columbus February 23, 24, and 25, 1988.

The conference included a Tuesday evening panel discussion and community forum, attended by 800. Television actor John Callahan was a guest at this session and spoke to the group. (He is in the TV series, *Falcon Crest*).

The Professional/Community Seminars held at the Columbus Iron Works Convention and Trade Center from 9 AM until 4:30 were attended by 650.

The Conference was funded by a grant from the Abbott Turner Fund and donations from the local business community.



*This billboard was part of the Muscogee County Medical Society's promotion of a public forum last February to inform citizens about AIDS. The forum was funded by a grant from the Abbott Turner Fund and donations from local businesses.*



# CALENDAR

## APRIL

22-23 — *Atlanta: Georgia Chapter, Baptist Medical — Dental Fellowship Annual Meeting.* Contact Teresa Clark, M.D., 490 Peachtree St., Atlanta 30308. PH: 404/688-8960.

22-24 — *Augusta: The Specter of AIDS — A Practical Conference for Health Professionals.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

23-27 — *Sea Island: Masters in Gynecology and Obstetrics.* AMA Category 1 and ACOG cognate credits. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

28-29 — *Atlanta: Pharmacology of the Anesthesiologist.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH: 404/727-5659.

28-May 1 — *Savannah: Medical Association of Georgia House of Delegates.* Contact MAG, 938 Peachtree St., Atlanta 30309. PH: 404/876-7535 or 800/232-0224.

30-May 1 — *Atlanta: The Cardiac Patient.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

## MAY

1-4 — *Sea Island: Georgia Society of Ophthalmology.* Category 1 credit. Contact Ray Williams, GSO, 938 Peachtree St., Atlanta 30309. PH: 404/876-7535 or 800/227-0778.

5 — *Atlanta; 6 — Statesboro: Soberfest® Conference — Alcohol and Drug Abuse: A Day with the Experts.* Category 1 credit. Contact Susan Pajari, Willingway Hospital, 311 Jones Mill Rd., Statesboro 30458. PH: 912/764-6236 or 800/242-4040.

2-6 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

2-7 — *Augusta: Primary Care and Family Practice Symposium.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

4-6 — *Atlanta: Selected Procedures for the Management of Disorders of the Adult Foot and Ankle.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

5-6 — *Atlanta: Psychosocial and Family Issues Following Traumatic Brain Injury.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

5-7 — *Hilton Head Island, SC: Cementless Hip Replacement.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

5-8 — *Destin, FL: Anesthesia for the Transplant Patient.* Amer. Acad. of Anesthesiologists Assistants Annual Meeting, cosponsored by Ga. Socy. of Anesthesiologists. Category 1 credit. Contact AAAA, P.O. Box 77253, Atlanta 30357. PH: 404/727-5910.

9-10 — *Atlanta: Quantitative Thallium Myocardial Tomography.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

12-15 — *Savannah: Georgia Radiological Society.* Category 1 credit. Contact James Moffett, 938 Peachtree St., Atlanta 30309. PH: 404/876-7535 or 800/282-0224.

13-14 — *Atlanta: Phacoemulsification Technique.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

14-15 — *Augusta: Pathology Symposium.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

20-21 — *Unicoi State Park: Georgia Rheumatism Society Annual Meeting.* Category 1 credit. Contact Richard Field, M.D., 3126 Exeter Rd., Augusta 30909. PH: 404/733-7848.

23-26 — *Atlanta: Science and Medicine.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

28-29 — *Sea Island: Georgia Neurosurgical Society.* Category 1 credit. Contact Herman Flanigin, M.D., Secy-Treas., MCG, Augusta 30912. PH: 404/828-3071.

### MAG MUTUAL INTRODUCTORY SEMINAR "GOOD PRACTICE POLICIES"

Half-day seminars are scheduled:

**Atlanta** — April 13 & 14

May 18 & 19

**Savannah** — April 28

**Columbus** — June 16

Category 1 credit offered. Contact Wanda Duren at MAG Mutual Insurance Co., 404/842-5600 or 800/282-4882.



# Highlights of County Activities

*(Editorial Note: The activities of the county auxiliaries this past fiscal year have been many and varied — and a complete reporting of them is not within the scope of this issue. Because of editorial space constraints, therefore, we asked the counties to report on only one or two of their major projects to give our readers a sampling of the scope of their involvement in health care projects throughout the state. Many auxiliaries worked on such varied projects as Tobacco Hazards, Safety, AIDS, Drug Abuse, Legislation, Teen Pregnancy, to name a few. What follows are highlights of those projects.)*

## Baldwin County

**T**he Baldwin County Medical Auxiliary chose the Head Injury Program as one of its projects for the 1987-88 year. The group committed themselves to the support of the Delphi House — a home for head injury patients — in Eatonton, Georgia. Some auxiliaries made Christmas dolls and sold them for \$15/\$20 a set, with the profits going to the Delphi House patient benefit fund.

During the holidays, auxiliaries provided music and singing for Delphi House patients. Continued support was given throughout the year, with basic needs being provided for those patients who had no income.

Another auxiliary project was working with the Baldwin County Health Department providing and keeping in working condition car seats for the community to rent at a very low price. K-Mart proved to be a real Santa last December by giving a special price and making it possible to buy 25 new car seats.

This has been a very successful on-going project for the Baldwin Auxiliary.

## Bibb County

**A** dinner-auction, the Holiday Sharing Card, sale of Sally Foster gift wrap, a candy-making class, and participation in the A-MAG auction made possible contributions of over \$10,000 to AMA-ERF by the Auxiliary to the Bibb County Medical Society.

Another focus of the Auxiliary was implementing the program, "Postponing Sexual Involvement — You Can Say No." This MAG-sponsored health-education project was first presented to all the seventh graders at one Macon school as well as a group of 17 junior and senior peer helpers who would train to use the material with another grade. Auxiliaries then planned to lead sessions of the program at other schools in Bibb County as arrangements were made.

## Cobb County

**M**ake It, Bake It, Sew It, Grow It has been the theme for the annual auction meeting held by the Cobb County Medical Auxiliary. November is auction month, and this proves to be a perfect time for auxiliaries to show their many talents — especially in needlework and baking. For those who win the bid, it is a great time to buy original gifts and stock their freezers for the holidays. Whether it be a hand-crafted article or white elephant, part of the fun is to see what will be available. Our own



*Bibb County auxiliary Betti Huckaby teaching Postponing Sexual Involvement to a Bibb County classroom.*



members volunteer their time and talent to be auctioneer and helpers. For a couple of hours they entertain us with their wit and clever remarks, encouraging friends and guests to bid on items they never knew they needed — much less wanted! In this short time, it is possible to make a thousand dollars.

Cobb's auction began in 1976, and over the past 12 years more than \$12,000 has been raised. These funds have been donated to such projects and organizations as AMA-ERF, MAG's Impaired Physicians Program, Calvary Children's Home, Our Lady of Perpetual Help (a home for terminally ill cancer patients), Open Gate (a temporary shelter for abused children), and to purchase portions of the Learning Center.

This year, Cobb has emphasized and presented programs on AIDS and other Public Health issues, postponing sexual involvement, maintaining a good medical marriage, etc.

#### *DeKalb County*

**T**he 1987 Holiday Sharing Card had a special meaning for members of the DeKalb County Medical Auxiliary. The front of the card was designed by one of the children who had benefitted from the Auxiliary's program of having 30 underprivileged children examined by an ophthalmologist and then purchasing correctly fitted eyeglasses. (All children receiving eyeglasses were given a chance to design the greeting card, and the winner was presented a \$50.00 savings bond.) Participation in the Sharing Card made possible a donation of \$3,000.00 to the DeKalb Health Department.



*DeKalb County auxilians (L-R) Pat Daly, Linda Bobo, and Billie Rountree showing the Christmas Sharing Card that was designed by one of the children receiving a free eye examination by an ophthalmologist. The card was sold to raise money for children in need of eyeglasses.*

A new DeKalb Auxiliary project this year was the joining with the Medical Society to begin formation of a medical support group to help colleagues involved in liability suits.

#### *Dougherty County*

**D**octor's Day held special significance in Albany this year, thanks to a project conceived and coordinated by the Auxiliary to the Dougherty County Medical Society. As envisioned by Auxiliary President Connie Adams and Doctor's Day co-chairpersons, Mary Linda Cotten and Karen Berg, this project both honored Dougherty County doctors and educated and informed the community about today's most challenging public health crisis — AIDS. The Auxiliary, in partnership with the Dougherty County Medical Soci-

ety, Phoebe Putney Memorial Hospital, and HCA Palmyra Medical Centers, presented a community-wide forum on March 14 at the Albany-James H. Gray, Sr., Civic Center entitled, "Your Family and AIDS."

The program was open to the public and carried live by radio throughout Southwest Georgia. The NBC-TV affiliate in Albany taped the program in its entirety for presentation at a later prime time date.

The education was provided by a distinguished panel of experts comprised of Dr. Harold P. Katner from Macon, Dr. John H. Curtis from Valdosta, and Dr. Paul C. White, Jr., from Albany. Each panel member brought particular expertise and gave a prepared presentation. After each, with a local medical doctor acting as moderator, there was a question-and-answer period for direct communication with the audience.



The planning and execution of such a major event required the involvement of almost every auxiliary in some way. Committees worked handling media coverage, outdoor marquis advertising, invitations to churches, schools, civic organizations, poster displays — and arrangements for the civic center facility.

This project provided a unique way for the Auxiliary to honor its doctors and also offer a much-needed service to Albany and to Southwest Georgia.

*"Your Family and AIDS" was the subject of a community-wide forum on March 14 in Albany sponsored by the Dougherty County Medical Auxiliary, the Dougherty County Medical Society, Phoebe Putney Memorial Hospital, and HCA Palmyra Medical Centers. Shown here is Dr. Harold P. Katner, of Albany, one of the speakers.*

#### Georgia Medical Society

The Auxiliary to the Georgia Medical Society last December joined other community

groups in the Festival of Trees, held in Savannah. Proceeds from this Festival go to the Department of Family and Children's Services. The Medical Society bought a 7-foot tree and designated the Auxiliary to decorate it — which they did with handmade ornaments, carrying out the Teddy Bear theme.

The tree was later given to the Ronald McDonald House playroom, which the Auxiliary furnished with toys in July of 1987. A Christmas dinner and party for Ronald McDonald House residents — adults too — was held. A surprise visit from Santa and his elves highlighted the evening, and the event was covered by the local TV station. Afterwards, teddy bears donated by auxiliaries were taken to the Pediatric Unit of Memorial Medical Center.

Together, the Medical Society and the Auxiliary made a real difference to the Ronald McDonald House residents and to the children in the hospital during the holidays.



*A surprise visit from Santa to the residents of the Ronald McDonald House in Savannah highlighted the evening planned by the Georgia Medical Society to benefit the children there. The event was covered by a local TV station.*

#### Medical Association of Atlanta

The TORT Show (Talent on Review Tonight), "An evening of fun, good food, and fabulous entertainment," was presented last October 8 by the Medical Association of Atlanta and its Auxiliary. Held at the Academy of Medicine, the evening began with a complimentary cocktail and dinner party — sponsored by the Nally Leasing Company. The audience then moved into the auditorium where they were dazzled by the performance of singers, dancers, piano players, a band, and even a visit from Bergen and McCarthy. Jan and Bill Collins acted as M.C.s for the evening as the show followed the format of an old time radio show. There were commercials on the show with a favorite being given by Ingrid Brunt, portraying a cigarette girl who sold "No Smoking" pins and cried out, "Don't call for Phillip Morris!" The TORT show was proposed and developed by Dr. Gwynne T. Brunt, president of MAA and Mrs. Judy Domescik, President of A-MAA.

The A-MAA also joined MAG's efforts to inform the public about AIDS by asking its members to attend the American Red Cross training sessions for AIDS Education facilitators. On January 19 and 20, nine Auxiliary members attended such a session and thus became certified to speak about AIDS to PTAs and other interested groups in the community. Marilyn Self, director of Atlanta's branch of the American Red Cross, spoke to the Auxiliary membership at its February meeting and continued to solicit support for this important project.

The other major thrust of the A-MAA for 1987-88 has been devoted to supporting A-MAG legislative programs.

#### Muscogee County

During the month of March, 1988, each mother and her newborn baby received a present





*Dr. and Mrs. Bill Collins hosted the TORT Show presented by the Medical Association of Atlanta Auxiliary last October.*



*Ingrid Brunt portraying a cigarette girl who sold "No Smoking" pins and cried, "Don't call for Phillip Morris!" at MAA's TORT Show.*

from the Auxiliary to the Muscogee County Medical Society. The baby's gift was a cute "I'm a Born Non-Smoker" T-shirt. The mother's package contained special information explaining some of the hazards caused by smoking and the disadvantages of living in a smoke-filled environment. The Auxiliary worked with the American Lung Association of Georgia on this project in honor of Doctor's Day.

In February, the Auxiliary co-sponsored a CPR course with the Columbus Junior League Society. The course was given by the American Red Cross.

As part of their Mental Health project, the Auxiliary distributed pamphlets entitled "Miscarriage" to patients at the Medical Center.

#### *Richmond County*

**"Reach Out and Teach Someone"** might be the name of the project implemented by the Richmond County Medical

Auxiliary this year. Investigation showed that a need existed for the public to be informed about AIDS and that the Red Cross needed trained people to teach this program in churches, businesses, schools, and other organizations.

The Auxiliary repounded to the need, and more than 15 members were trained and presented certificates by the Red Cross. The Auxiliary hopes to continue the program and to expand its participation in presenting the facts to the public.

Many Auxiliary members helped on a Suicide Prevention project, bundling flyers and distributing posters to Richmond County public and private schools. Each of the 3,500 students took home a flyer informing the parents of the signs of depression and phone numbers to call for help. The Augusta Mental Health Association reported that the response from this project was overwhelming.

The Anti-Tobacco Program for all fifth graders in Richmond

County was continued this year, and the child abuse puppet show was presented to the third grades in March.

#### *Tift County*

**T**he theme for Tift County Medical Auxiliary this year has been "Up, Up and Away . . . Serving Our Community," with most of the service projects being focused on the needs of adolescents and their families. A unique need was discovered last fall as a result of the Auxiliary's educational programs in the junior and senior high schools. For the first time this year, the Tift County School system offered a class exclusively for pregnant teenagers. The purpose of the Teenage Parenting Class (TAP) is to prevent school dropout; to provide education, vocational and parenting skills necessary to prepare these teens for the future — and to decrease the incidence of future teenage pregnancies in this group.





*Richmond County's medical auxiliary was involved in an Anti-Tobacco Program that presented slides to school children showing how advertising is used to promote tobacco use.*

The Tift County Medical Auxiliary first became involved in helping the new class by donating kitchen items needed to teach basic homemaking skills. Contacts with the teacher revealed further opportunities for volunteers to support, nurture, and provide educational services for these teens. In December, the Auxiliary voted to explore the possibility of "adopting" the TAP class through Tift County School system's new "Adopt-a-School" program. The program director was elated with the proposal, and it was finalized in January. Future plans are for Auxiliary members to become involved more directly with the 15-20 girls in the class. Suggested projects include donating maternity and baby clothes, teaching classes on prepared childbirth and breastfeeding, and tutoring individual students. This project has already proved to be very rewarding, especially to those auxiliaries with young children. And, because many members from the teaching, nursing, and other professions are Auxiliary members, there are numerous possibilities for the Tift County Medical Auxiliary to be involved in this project for many years to come.



*The Tift County Medical Auxiliary worked with the Tift County School System on the Teenage Parenting Class (TAP), offered exclusively to pregnant teenagers to help prevent school dropout and to teach education, vocational, and parenting skills. Shown here (L-R front row) are Fran Vickers, TPA class teacher; Susan Griffin, TAP Committee Chairperson; Gwen Walker, Adopt-A-School Director; (L-R back row) Leigh Deese, auxilian; and Barbara McCoy, Auxiliary President.*



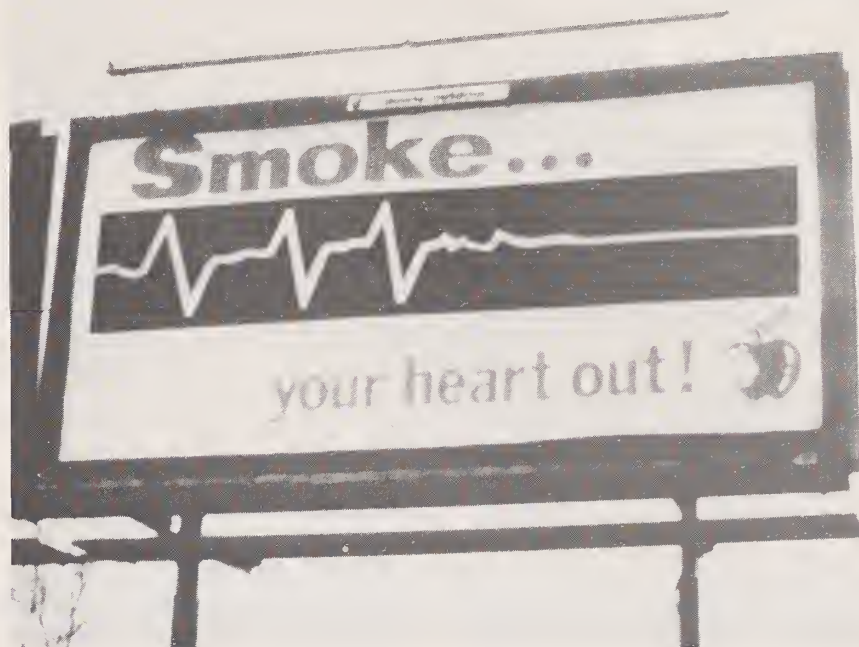
### *Troup County*

**I**n 1984, Troup County auxilian Glenda Major began a research into the history of medicine in LaGrange and Troup County. Going back to the inception of the County in 1827, Glenda's research has taken her into the homes of some of the ancestors of physicians who practiced in this area, cemeteries throughout the County, libraries, the Troup County Archives (where many hours were spent reading old newspapers), the county census, and the Troup County Courthouse where the County records are kept.

The Troup County Medical Auxiliary is assisting in this worthwhile project, which they hope to see published in the very near future. Current plans are for the history, covering the first 100 years of the County's existence, to be printed in book form. Auxilians are helping Glenda — who has almost completed her research and the writing of this history — by editing and proofreading each chapter, and by gathering pictures, artistic drawings and other materials that can be used to illustrate this work.

### *Walker-Catoosa-Dade*

**T**he Walker-Catoosa-Dade Medical Auxiliary this year served as liaison between the high schools of these counties and the Chattanooga-Hamilton County Medical Auxiliary for the presentation of the second annual Teen Health Workshop called "Facts to the Future." The Fair was held on March 4, 1988, at the University of Tennessee at Chattanooga, with approximately 500 teenagers and adult school representatives attending. The workshop was designed to encourage and support East Tennessee and North Georgia teens in making healthy, positive decisions regarding their physical, mental, and emotional well-being.



*Working with Doctors Ought to Care (DOC), the Richmond County Medical Auxiliary supported counter-advertising such as this billboard. An excellent slide presentation was developed showing the seductive nature of tobacco advertising.*



*(L to R): Priscilla Hammond, the Northwest Georgia Occupant Safety Coordinator; Karen Heusel, Statewide Coordinator for Car Safety, Safety Belt Education Program; and Sandra Burns, A-MAG State Safety Chairperson. Educating auxiliary members on the importance of the proper use of child restraint devices was one of the goals of the A-MAG State Safety Committee.*



## Good Times are Safe Times

Parties, proms, and outdoor recreation are great memories in the making.

Please be careful. Don't drink and drive. Don't do drugs. Do wear your seatbelt. And remember that diving, falls and other freak accidents are among the leading causes of paralyzing spinal cord injuries.

Thank you.

**Whitfield-Murray County  
Medical Society and  
Auxiliary**

*In Whitfield-Murray County, one of the Safety Committee's projects, designed to honor local doctors, was the inclusion of this card, "Good Times are Safe Times," placed in the corsage boxes and tuxedo pockets of high school students attending balls and proms.*

Laura Crawley's outstanding brochure entitled *Say No to Drugs, Man, Say Yes to Life for Sure* was included in the workshop's folder which was given to each student attending.

TV personality Cloris Leachman and Dr. John W. Green from Vanderbilt University headed a group of outstanding speakers assembled to share their insights and knowledge.

As an extension of this project, the Auxiliary has distributed 500 of the brochures to the Public Health Department of Waker-Catoosa-Dade. A tape emphasizing the "Say No to Drugs" message is being made by a Sheriff's Depart-

ment Lieutenant and will be available to any classroom teacher who requests it.

### *Whitfield-Murray County*

**T**he Whitfield-Murray County Medical Auxiliary sponsored an Occupant Protection Training Workshop on September 30, 1987, at the Bradley Wellness Center in Dalton, Georgia, and also participated in Hamilton Medical Center's World of Health. Many members staffed booths and helped in colo-rectal or breast screening areas.

The Auxiliary's Safety Commit-

tee has presented a "Special Car Seat" to Dalton's Community Developmental Services. This seat is designed for children with limited upper torso strength who need more support and protection than is provided by a regular car seat. Ten additional car safety seats for Whitfield County Health Department's loaner program have been ordered.

Another of the Safety Committee's projects, designed to honor the local doctors, was the inclusion of a "Good Times are Safe Times" card placed in the corsage boxes and tuxedo pockets of high school students attending balls and proms.



# Seat Belts Save Lives!

Robert A. Burns, M.D., F.A.S.

**S**EAT BELTS SAVE LIVES AND REDUCE INJURIES.

That is an important statement, and it should be of concern to anyone interested in preventive medicine. The automobile accident remains the number one killer of children and young adults. If everyone buckled up, we could save 15,000 lives in this country each year.

We have been aware of the benefits of seat belts for decades. And yet it seems that most people have been slow to adopt the important safety practice of "buckling up." Fortunately, things are changing. Just a few years ago, only 11% of American adults regularly wore seat belts. Today, 35% of adults and 65% of children are seat belt users.

**A**t one time, mandatory seat belt laws were given little chance of passage in the United States. Today, seat belts laws are on the books in 31 states, and other states are considering such legislation. All states have adopted mandatory child restraint laws.

A little over 5 years ago, when seat belt usage was placed on a list of issues that concerned the public the most, it ranked 350th in importance. However, a more recent poll ranked seat belt usage

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***The Auxiliary to the MAG has been active in promoting seat belt usage. The Auxiliary initiated car seat loaner programs long before the child restraint laws became effective. Passage of a mandatory seat belt law has been a top priority of theirs this year.***

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third on a list of public health concerns. A recent study conducted by the University of Georgia revealed widespread support for a mandatory seat belt law in Georgia. And at the grass roots level, organizations have been formed to promote seat belt usage.

What has caused this change in attitude? And why has it taken so long to develop? To answer these questions, let's go back a few years.

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Dr. Burns is a General Surgeon and a member of the Auxiliary to the Medical Association of Georgia's Advisory Committee. Send reprint requests to him at P.O. Box 129, Dalton, GA 30720.

**S**eat belts have been installed in automobiles for over 20 years. Their value has been proven in numerous studies. Lap belts are effective in reducing fatalities by 37%. Lap and shoulder belts together reduce fatalities by 55%. Yet despite their demonstrated effectiveness, very few people were using seat belts. This was frustrating to those of us who took care of the victims of automobile accidents. As we looked on, we saw thousands of lives lost needlessly each year. And we witnessed mutilating and crippling injuries that could have been prevented or lessened by buckled seat belts.

But if seat belts were so wonderful, why weren't people using them? Safety engineers and behavioral scientists set out to answer this puzzling question. One of their most publicized findings was the infamous list of excuses that people gave for not using seat belts. High on this list was the fear of being trapped in an automobile following an accident.

It was this list that became the basis for just about every public information campaign. "Exploding the seat belt myths" is a phrase that we have heard repeatedly over the past 2 decades. Unfortunately, myths die hard. And the public in-



formation campaigns had little success.

As it turned out, myths were not the real problem. It was more basic than that. Whatever excuses people were giving for not buckling, the main problem was a lack of awareness. When people got into their automobiles, they simply did not think about seat belts. In fact, most people regarded seat belts as useless accessories. And they ignored them.

**T**o solve this problem, engineers designed ignition systems that would not function unless the seat belts were fastened. The public protested loudly, and this idea was quickly abandoned. In its place we were given lights and bells that flash and ring for a few seconds after the car is started. These gentle reminders to buckle up were much more palatable. But they were also much easier to ignore. So the question remained. How do you get people to buckle up?

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***But if seat belts were so wonderful, why weren't more people using them? One of the "myths" was the fear of being trapped in an automobile following an accident.***

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One obvious answer was a mandatory seat belt law. Over 20 foreign countries had already tried this with varying success. Usage ranged from 15% to 90% in those countries. It was predicted that a mandatory seat belt law would increase usage in our country by at least a factor of two. Unfortunately too many people considered this a "freedom of choice" issue, and

this idea was given little chance of success.

There were exceptions, however. A few companies adopted mandatory seat belt policies in an effort to reduce the cost of automobile-related injuries and fatalities. There were laws that required school bus drivers to wear safety belts. But there was another big exception. Infants and small children were considered immune from any "freedom of choice" arguments. They were simply too young to be able to make an intelligent choice about seat belts.

And the research data were impressive. Up to 90% of fatalities could be avoided if children and infants were secured in a properly installed child restraint device. It became an issue of protecting our children. As such, it was more closely akin to mandatory vaccination laws.

**T**ennessee was the first state to pass a mandatory child restraint law. The other 49 states followed suit. But even before the laws went on the books, child restraint became an issue of public concern. Pediatricians supported "First Ride, Safe Ride" programs. The Auxiliary to the MAG started car seat loaner programs. Anxious to be good parents, people started taking their newborn children home from the hospital in infant restraint devices. Suddenly it was impossible not to think about seat belts. Each time a child was buckled or unbuckled, seat belt consciousness was raised.

**T**his was the turning point. For the first time, parents started teaching a new generation of children to be bucklers. And in the process, they began noticing the seat belts they had previously ignored.

There is another important factor that deserves mention. The auto industry has recently spent a great deal of time and money lobbying for passage of mandatory seat belt laws. They hoped that this would forestall federal regu-

lations requiring them to place passive restraints in all newly manufactured automobiles. Such restraints would increase the cost of the car and might result in increased liability for the manufacturers.

The lobbying has been successful. Over half the states now have mandatory seat belt laws on the books. However, the child restraint laws were passed first. And I believe that they laid the ground work for everything that has followed.

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***A little over 5 years ago, when seat belt usage was placed on a list of issues that concerned the public the most, it ranked 350th in importance.***

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**T**he Auxiliary to the MAG has been active in promoting seat belt usage. The Auxiliary initiated car seat loaner programs long before the child restraint laws became effective. Passage of a mandatory seat belt law has been a top priority of theirs this year. And most recently, the Auxiliary has turned its attention to important new problems. Currently, only 35% of Georgia's children are being restrained in accordance with the law. And research indicates a car seat misuse rate of 70%. Either the car seat is improperly installed in the car, or the child is improperly secured in the car seat. Such errors can be deadly.

So despite the progress, we still have a long way to go. As physicians interested in preventive medicine, we should support efforts to enact a mandatory seat belt law in Georgia. We should work to strengthen the existing child restraint laws. And we should continue to educate our patients on the importance of buckling up. ■



# Malpractice: Is Competence or Caring In Question?

Betty Castellani

**T**HE HOSPITAL JUST CALLED and notified you that the file on your patient has been requested by a lawyer. You leave your office that day feeling like you are in a different world than when you arrived. Fear enters your life and it seems to color everything that you do. Whom do you tell? Do you tell your associates? Do you call your lawyer? Do you share this news with your family? Does it change the way you practice medicine, relate to your peers, interact with your family? What effect will that phone call from the hospital records room have on your life for the next two years, until the statute of limitations runs on a negligence cause of action?

According to the February 13, 1987, issue of the *Journal of the American Medical Association*, in 1985, the number of claims per 100 doctors was 17.8, a 57% increase over its 1981 rate. It was also reported that claims against physicians who performed no surgery, no invasive procedures, and no obstetrical procedures increased by 100% from 1981 to

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***It is impossible to be an open, caring doctor when you are afraid. If you are afraid that anything you say can be used against you in some lawsuit, you choose your words carefully. . . . Patients feel the distance. But patients do not understand why it is there.***

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1985. The numbers are significantly higher for 1986. Why?

There are many acceptable excuses for why doctors are sued. There is too much for any one doctor to know. There has been a literature explosion in all branches of medicine. People can no longer accept their mortality. When

something goes wrong someone must be blamed. There is too much economic pressure on doctors today. Malpractice insurance rates, HMOs, and government regulations on Medicare have taken their toll. There is not enough time to adequately chart and do follow-up care.

But I think the bottom line is that, for whatever reason, many doctors do not know how to transmit caring to their patients. The unalterable fact is that patients do not care how much a doctor knows until they know how much that doctor cares.

**I**f doctors had more time to read, if they spent more time in the medical library, if they charted 5 hours per day, if they took a yearly intensive course in continuing education, the incidence of malpractice suits would not drop one percentage point. But if they added 5 minutes to each patient's time with them and if they spent that 5 minutes looking at the patient, touching them, making them feel that nothing was more important to them right then than that pa-

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Ms. Castellani is Associate Chaplain and Counselor at DeKalb General Hospital. Send reprint requests to her at 2701 N. Decatur Rd., Decatur, GA 30033.



tient's problem, then malpractice cases would plummet.

I have been with patients, listened to their painful stories, heard many threats of malpractice lawsuits. I am not perceived by patients as a member of the hospital staff so they feel comfortable voicing their anger and frustration to me. I also work with doctors. I talk to them about malpractice. I listen to their concerns about their patients. I know that with very few exceptions they are caring, compassionate people. The threat of malpractice suits has ruined their lives and robbed them of their joy of practicing medicine. Malpractice has become to the medical community what AIDS is to the homosexual community. It is a tragedy and something must be done about it.

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***I think that for the most part doctors do a splendid job of investing their competence. What I am suggesting is that doctors pay more attention to investing their caring.***

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Patients used to love their doctors. One patient I saw recently told me that in terms of importance, her doctor came only after God. Why? "Because I know he cares about me and he will do everything in his power to see that I get well." It would be impossible for that doctor to do anything to that patient that would end up in a malpractice action.

One doctor sent a patient to another specialist for a second opinion. That "specialist" made a statement that sounded critical of the referring doctor, the one the

patient loved. The patient left with great fury because her doctor had been criticized.

**B**ut it is impossible to be an open, caring doctor when you are afraid. If you are afraid that anything you say can be used against you in some lawsuit, you choose your words carefully. If you are afraid that every deed you do is going to be held under a microscope, you operate within a very narrow framework. If you are afraid that every patient might attack you, you put on your armour.

Patients feel the distance. But patients do not understand why it is there. It prevents any real closeness from developing between the patient and the doctor. No one can love a textbook or relate to an impressive body of medical language. Fear can prevent doctors from delivering the caring most patients want most.

**S**ome doctors feel genuine frustration and helplessness because they know how good they are at what they do and yet they sense that the patients do not even care. Surgeons are generally referred to patients by an attending physician. I have never known a patient to ask a surgeon where he went to school or what kind of fellowships he received, or how high he graduated in his class. Let me give you two actual examples of how this visit is handled. One surgeon walks in, gives her name, tells the patient what she is going to do, what the possible side effects are, gets a permission slip signed and walks out. Another surgeon walks in, sits on the foot of the patient's bed, never takes his eyes off of the patient, explains everything in detail and tells the patient that as far as he is concerned, nothing will be more important to him than that patient's recovery. He assures the patient that he is in no hurry. He will answer any questions now and if some come up later he can be reached by phone.

The first surgeon left the patient feeling like a chart rather than a person. She felt out of control and at her mercy and very angry at the situation. The second surgeon left the patient feeling special. The length of each visit was roughly the same. The first surgeon may have been by far the best in terms of technical skill. However, that surgeon runs the greater risk of getting sued if something should go wrong.

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***The unalterable fact is that patients do not care how much a doctor knows until they know how much that doctor cares.***

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If you think I am giving you a simplistic answer to the most critical problem facing the medical profession today, think again. What I am suggesting is that you be willing to really look at your hurting patients, really listen to their tears, really acknowledge what has happened to them. Then you will understand that what I am suggesting is very hard to do and requires from you all of the caring and compassion that must have been there when you made the decision to go into the practice of medicine.

**T**hink of it in terms of an investment. Any doctor who has been sued can tell you that the time investment in a lawsuit is astronomical and there is absolutely no way to calculate the time spent in anguish, sleeplessness, frustration and despair. No one would argue against the fact that a malpractice suit is a catastrophic time expense with dismal returns regardless of the outcome. I am suggesting preventive investments.

Patients do not believe that most doctors ever listen to them. Invest



a few minutes really paying attention to what your patient is saying. Patients do not believe that most doctors really care about them as people. Ask them about their families. Patients do not believe that most doctors know how devastating their news can be. Let them know you understand. Call them on the phone in a few hours after you have delivered some bad news and ask them how they are doing. Those kinds of investments will pay remarkable dividends. I think that for the most part doctors do a splendid job of investing their competence. What I am suggesting is that doctors pay more attention to investing their caring.

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***What I am suggesting is that you be willing to really look at your hurting patients, really listen to their tears, really acknowledge what has happened to them. . . . Think of it in terms of an investment.***

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**I**f a doctor invests his or her competence, monetary payment will be received. But if a doctor invests his or her caring, the dividend will be a patient's love and loyalty. The most remarkable result of changing the way of investing is that the doctor will rediscover the joy of practicing medicine. It really is a profession that gives a person the opportunity to make a tremendous difference in the lives of many people. That doctors have lost that joy is the saddest and most intolerable result of the malpractice crisis. ■



**WOODRIDGE**

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# Have You Hugged Your Lawyer Today? But Seriously, Doctor . . .

Robert L. Steed

I WAS A BIT SUSPICIOUS when my secretary of 20 years, Yvonne—"I-didn't-go-to-Marsh-Business-College-for-3-months-to-learn-how-to-fetch-coffee-for-you"—McMillian, told me that folks from the *Journal of the Medical Association of Georgia* were trying to get in touch with me. Sensing my anxiety, she said soothingly, "Don't worry, they probably just want you to pose for a few photos on an upcoming article on stretch marks."

Nowithstanding her reassuring speculation, it occurred to me that these weren't the best of times for doctors and lawyers in terms of professional relations, and I certainly wasn't eager to put my head in the lion's mouth gratuitously.

When I finally worked up the courage to return the call left by a member of the magazine's publications committee, the distinguished surgeon, J. Rupert

"Thumbs" Tillabaugh, I was informed that they wanted a "light-hearted piece that might bring a smile to the lips of readers of the *Journal of the Medical Association of Georgia*." I expressed some reluctance to the good doctor about my ability to lighten or enliven the *Journal*, but he urged me to review a few copies before saying no. After poring over some scintillating expositions on fascinating subjects ranging from "Symptoms of Irritable Bowel Syndrome" and "The Efficacy of Measuring Bone Mineral Density in Asymptomatic Women: A Preliminary Report" to "Clinical Management of Endocrine Disorders,"

Mr. Steed is an Atlanta attorney and dilettante columnist for *The Atlanta Constitution* where his columns appear at random. His latest published collection is *Money, Power and Sex (A Self-Help Guide for All Ages)* and is available at Atlanta book stores.

I decided that perhaps a bit of froth certainly couldn't wreak any permanent havoc and might well punch up the *Journal* for a brief moment.

Filing with Dr. Tillabaugh in advance a caveat that all of my writings were accompanied by some contraindications, such as acute fulminations from over-serious readers, oral foaming, involuntary spasms and sputtering on the part of the acutely dignified, and sphincter rigidity in those with known sensitivity to feeble attempts at humor, I finally agreed to attempt a piece for the *Journal*.

The thought that doctors (or those who often take themselves more seriously about being doctors than the doctors do themselves, that is, doctors' wives), might take offense at finding an intruder from the legal profession flopping about in the deep and serene waters of the *Journal* gave me some pause but it was only



momentary as I reasoned that I, as a municipal bond attorney, wasn't a *real* lawyer after all and thus could probably lay claim to more objectivity on the subject of professional relations than someone who actually tried and prosecuted lawsuits. After all, one of my litigator law partners, Byron "Whiplash" Attridge, once described municipal bond attorneys as "people with not enough personality to be tax lawyers but with too much personality to be CPAs."

As someone who has flogged himself around the State addressing Bar conventions and medical associations, I have indeed had an opportunity to give thoughtful reflection and temperate expression to the decline in cordiality between the two professions. Frankly, I believe that one of the root causes of this hostile quandary in which we find ourselves locked is a loss of self esteem among members of both professions. Indeed, who can blame either profession for feeling a slight downward shift in dignity when we

***“After poring over some scintillating expositions on fascinating subjects ranging from ‘Symptoms of Irritable Bowel Syndrome’ . . . to ‘Clinical Management of Endocrine Disorders,’ I decided that perhaps a bit of froth certainly couldn’t wreak any permanent havoc . . .”***

find on every cable television channel some huckster lawyer importuning the sick, lame, and halt (not to be confused with the small law firm in Marietta by the same name) to drop by for a free consultation on their legal woes, or see in every shopping center some docs in a box called the “24 Hour EmergiCenter, Ear Piercing Clinic, and Video Rental.” Perhaps a return to more dignified times when lawyers wore vests and doctors had unlisted phone numbers would be better for all of us. However, times change, and we must accommodate the change without getting too bitter and resentful about it all.

**O**f course, I can’t speak about the sensitivities of physicians in terms of loss of self-esteem, but in the area of public relations, lawyers have long been notorious victims. Throughout history, they have been pilloried in song, verse, and print by an unforgiving and misunderstanding public. This has, at times, made them jealous and resentful of their brethren in the medical profession.

As a member of that beleaguered brotherhood at the Bar, I am always confounded as to why it is that in every public opinion poll ever taken, doctors and, specifically, surgeons, are always right up there at the top with scientists, astronauts, and Mother Teresa, while lawyers find themselves in a knot at the bottom of the pile with used car salesmen, carnival greeks, chiropractors, and Congressmen. After all, the law was a noble and enduring profession when medicine involved little more than pulverizing frog eggs, lizard spleens, and yak antlers, and surgery was still primarily a sideline practiced by barbers.

**S**ome have suggested as a cause for the widespread and

***“As a member of that beleaguered brotherhood at the Bar, I am always confounded as to why it is that in every public opinion poll ever taken, doctors and, specifically, surgeons, are always right up there . . . with scientists, astronauts, and Mother Teresa, while lawyers find themselves . . . at the bottom . . . with used car salesmen, carnival geeks, chiropractors, and Congressmen.”***

notorious unpopularity of lawyers that there are simply too many of us and, indeed, this is becoming a growing theme for an unrelenting and sensationalist press.

As I have said before in my newspaper column and from the stump, this notion is sheer nonsense. In point of fact, this country at present has only 750,000 lawyers, more or less, with the result that many people don't even have a lawyer of their own but are forced to share one. This is not only inefficient, but depending upon the particular lawyer, downright unsanitary.

No, even in olden days, when there were far fewer legal practitioners, there was an unreasoning prejudice against lawyers. The drafters of Georgia's original Charter provided that it was to be "a happy, flourishing colony . . .



free from [as they diplomatically phrased it] the pest and scourge of mankind known as lawyers." Shakespeare's Dick the Butcher, reacting enthusiastically to Cade's Utopian vision, urged, "The first thing we do, let's kill all the lawyers." Carl Sandburg wrote with malicious and alliterative glee, "Why does the hearse horse snicker when he's hauling a lawyer away?" And even St. Luke (a known physician) took a gratuitous jab in Chapter 11, Verse 46, with "Woe unto ye lawyers also! For you load men with burdens hard to bear, and you yourselves do not touch the burdens with one of your fingers."

***“Doctors are proud to be doctors. They have little signs on their automobile license plates advertising the fact that they are doctors. (This also permits them to park in spaces which would otherwise be reserved for crippled people.)”***

Every day seems to bring a new bad joke about lawyers, e.g., "What do you get when you cross a lawyer with a Godfather?" Answer: "Someone who makes you an offer you can't understand."

Some weaker members of the legal profession actually crack under the strain of this bad press. I know a lawyer who drives a bread truck to and from his office in an attempt to prevent his neighbors from learning the true nature of his day job. Others, when confronted by their sobbing children who have been told by cruel and insensitive playmates that their parent is a lawyer, resort to guile and outright deception, telling

their children they are really cocaine traffickers, members of the General Assembly, or proctologists.

I have long pointed out to lawyers everywhere that doctors are entirely different in this respect and have a much larger quotient of self-esteem. As one lawyer friend of mine recently observed, "It's refreshing to see how much faith doctors have in themselves. Particularly in these troubled times when so many people believe in no God at all."

**I** tell lawyers that they can learn from practitioners of the healing arts in terms of self respect. It's simply a matter of self-esteem and pride in their profession. Doctors are *proud* to be doctors. They have little signs on their automobile license plates advertising the fact that they are doctors. (This also permits them to park in spaces which would otherwise be reserved for crippled people.) At movies, concerts, and cocktail parties, doctors happily proclaim their profession by wearing little beepers on their belts like old time gunslingers. Some of the younger doctors, having noted that typewriter repairmen also wear these beepers, will often go to a public gathering with a stethoscope hanging casually from their pockets just to avoid any confusion. I have seen doctors show up at formal gatherings in black tie wearing reflectors on their noggins. This does convey a certain panache to an otherwise humdrum outfit.

Moreover, if doctors get into a situation that is so crowded that people are likely to notice neither the electronic beeper nor the dangling stethoscope — a football game, for example — they will simply have themselves paged. I've long advocated having lawyers paged at football games. I think it would help their images tremendously. . . . "Lawyer 84, Lawyer 84, please call your office. You missed a mortgage when you checked that last title."

***“If an unexpected client happens to wander into a lawyer's office, they not only see him right away but generally fall on him like a school of piranha in a feeding frenzy.”***

Actually, the doctors are now claiming that there are too many doctors as well. I'd be a little more inclined to accept that claim if all doctors listed their home telephone numbers. Moreover, you have to make an appointment months in advance to see many specialists, not to mention getting up all the credit references. If an unexpected client happens to wander into a lawyer's office, they not only see him right away but generally fall on him like a school of piranha in a feeding frenzy.

**F**runkly, my prescription to both lawyers and doctors is nothing more than the wisdom long embodied in Rule 5 of the Kansas General Assembly. This paradigm of good common sense was promulgated by the Kansas General Assembly around the turn of the century and goes simply, "Don't take yourself so damn serious." I am persuaded that if practitioners in both professions would simply take themselves and each other a bit more lightly we would have made a great first stride in getting the proverbial lion and the lamb to lie down together. But, in all fairness, I should pass along to the doctors the admonition of that great American philosopher Ralph Waldo Emerson (I think it was Ralph Waldo Emerson; it was either Ralph Waldo Emerson or Shecky Green), who said, "The lion and the lamb may lie down together, but the lamb isn't going to get a hell of a lot of sleep." ■



# Practicing What We Preach

Sheldon B. Cohen, M.D.

**T**HE GOOD NEWS is that we physicians have markedly changed our consumption of tobacco products and are in the process of eliminating it from our offices, clinics, and hospitals. The not-so-good news is that some of us continue to be addicted to tobacco, some of our institutions lag in becoming tobacco free, but more importantly, we are all too often remiss in forthrightly dealing with our patients about their tobacco addiction. The good-news-to-come is that many patients will respond positively to our efforts to get them to face up to and deal with their addiction to tobacco. There are many straightforward things that we can do to reduce tobacco addiction among our patients.

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***We are all too often remiss in forthrightly dealing with our patients about their tobacco addiction.***

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1) **PHYSICIAN HEAL THYSELF.** If you are one of the constantly diminishing minority of doctors who continue to use tobacco, analyze the reasons for your continued dependence. Like most people, you may be able to quit on your own. If not, don't be ashamed to ask for help from a colleague, the ACS, ALA, or any other legitimate source of assistance.

2) **OFFER HELP TO ALL OF YOUR EMPLOYEES** in quitting tobacco use. See what their needs are. Pro-

vide opportunities for assistance. Give bonuses to nonusers of tobacco.

3) **LET YOUR OFFICE BE A MODEL OF A TOBACCO-FREE FACILITY.** Have tasteful, non-confronting signage, e.g., *You are respectfully requested to refrain from using tobacco in these offices.* Remove ashtrays, (one building put up NO SMOKING signs but they were next to ashtrays. Guess what people did!)

4) **ASK EVERY NEW PATIENT ABOUT TOBACCO CONSUMPTION.** Compliment those who have never used tobacco for their good judgment. Praise those who have been able to stop using tobacco. Find out how they stopped: it will be useful in your work with patients who are still addicted.

5) **IN A NON-JUDGMENTAL MANNER,** tell your tobacco-addicted patients the health benefits to be gained in becoming free of their addiction. Try to be empathic, emphasizing that tobacco addiction is the world's number one addiction, and that regaining their health may not be the easiest thing they have ever done, but it is well worth their efforts.

6) If your patient is willing, **INSTITUTE TREATMENT** immediately or refer to an appropriate colleague or facility.

7) **HAVE A SUPPLY OF LITERATURE** from the AMA, ACS, ALA, etc. that will give patients information and assistance.

8) **CUT YOUR PRACTICE COSTS.** Ask your insurers (health, life or casualty) for the preferential rate that you deserve for not having smokers on your payroll or allowing smoking in your offices.

9) **PAY SPECIAL ATTENTION** to those most helpless and in need of protection, i.e., children and fetuses. Emphasize the vulnerability of the immature body to parents and pregnant women. Recommend that they not allow their children or fetuses to breathe any tobacco, and that they not be in a room where tobacco smoke is present. ■

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Dr. Cohen practices psychiatry. Send reprint requests to him at 490 Peachtree St., Suite 251-B, Atlanta, GA 30308.



# Georgia Schools Help Teens Postpone Sexual Involvement

Kathleen Collomb, Marion Howard, Ph.D.

**A**N EDUCATIONAL PROGRAM designed to help 13-15 year olds postpone sexual involvement is being disseminated throughout the State of Georgia. The "Postponing Sexual Involvement" program, developed by the Emory/Grady Teen Services Program in Atlanta, Georgia, is structured to be given to both boys and girls in four to five sessions. Sessions last approximately 1-1½ hours. The program can be used in any setting where there are groups of youth: schools, youth agencies, churches, and so forth. A companion series is available for parents.

In 1985, the Emory University Department of Gynecology and Obstetrics and the Grady Hospital Teen Services Program offered free "Postponing Sexual Involvement" training and materials to any Georgia Health District who organized and sponsored a training session for individual volunteers in their area interested in presenting the prevention program to young people. The only obligation of the volunteers was to present the "Postponing Sexual Involvement" program to at least 50 youths. All but one of the 19 Health Districts took advantage of this offer and sponsored at least one ses-

sion between March, 1985, and March, 1986. Some Health Districts sponsored several sessions in response to community needs. In addition, several local agencies throughout the state also sponsored training sessions. Funds to provide the training and materials were granted to Emory University by the Office of Adolescent Pregnancy Programs of the United States Department of Health and Human Services.

Between March, 1984, and March, 1985, a total of 956 volunteers were trained in 46 training sessions. These volunteers were from a wide variety of backgrounds and organizations. The three main categories of individuals trained were teachers (228), nurses (183), and counselors (101). The major organizations sending volunteers to be trained were health departments, schools, youth-serving agencies, and churches. There were 163 males and 798 females trained. The race/ethnicity of those trained was Whites (619), Blacks (318), Span-

ish Origin (19) Asians/Pacific Islanders (19).

Although it had been envisioned that the initial training would be sufficient, word about the "Postponing Sexual Involvement" program spread rapidly, resulting in more groups or individuals wishing to be trained and given materials. Also, some groups who had learned about the program earlier found it took time to work through their own particular bureaucratic process to obtain necessary approval for use of the "Postponing Sexual Involvement" program or freeing individuals to receive training. A mailing to all Georgia School systems also stimulated further interest in the program. As a consequence, additional training sessions were scheduled, including two training sessions for teachers only.

As early as 1985, the Auxiliary to the Medical Association of Georgia also became interested in the program and in 1987 undertook supportive measures to encourage local school systems throughout Georgia to implement the "Postponing Sexual Involvement" program. Acquainting school systems with the "Postponing Sexual Involvement" program became a cornerstone of the

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MAG's "You Can Say No" Campaign. As a consequence of its commitment, the Auxiliary sponsored training sessions, had its own members trained, and worked with school systems to review and implement the program.

### State-Wide Survey Undertaken

As of the fall of 1987, the Emory University/Grady Hospital Teen Services Program had documentation sent in by trained volunteers that 27,000 youth had been reached with the program from March, 1985, through September, 1987. These youth had been reached through a variety of agencies and organizations. However, they were also aware that the use of the program had grown exponentially, particularly in school systems, and therefore a more accurate measure of the program's acceptability and ongoing use might be achieved through a survey of school systems. The Auxiliary to the Medical Association of Georgia felt such information would be particularly useful to them in their attempt to have the "Postponing Sexual Involvement" program adopted by school systems.

Therefore, over a 3-month period beginning late in October, 1987, the Teen Services Program conducted a survey on the use of the "Postponing Sexual Involvement" educational program by the 186 School Systems in the State of Georgia. The primary call was made to the curriculum director of each school system. However, as warranted, additional calls were made to teachers who were known to have been trained to present the educational program as well as school principals, subject coordinators, and rarely, school superintendents. In a few cases, conflicting information appeared to be given.

### Survey Results

As a result of the survey, it was learned that one third (64 of the 186) Georgia School Systems are currently using the "Postponing Sexual Involvement" program. Officials in the 64 school systems using the curriculum indicated that 26,000 students in the State of Georgia are being given the "Postponing Sexual Involvement" program on an ongoing basis. Six additional school systems will start using the program next year. Thus, during the 1988-89 school year, respondents indicated, on an ongoing basis at least 31,000 students annually will participate in the "Postponing Sexual Involvement" program. In addition, five other school systems are going through a review process and expect to implement the program once that process is completed, so the numbers of young people being given the program is expected to continue to increase.

The Survey also produced unexpected results in that key individuals in 109 school systems indicated they were either not familiar with the "Postponing Sexual Involvement" program and wanted to be sent information or had heard about it but wished to learn even more. Five of these school systems also expressed interest in finding out about teacher training for the program.

### Ongoing Sex Education Programs

One hundred and three (103) school systems in the State of Georgia indicated that they currently have a formal sex education curriculum in place. Of these, nearly half (47) are using the "Postponing Sexual Involvement" program. Of the fifty-two (52) school systems that indicated they did not have a formal sex education curriculum in place, five (5)

also had individual schools using "Postponing Sexual Involvement." The survey did not learn whether or not the remaining 31 school systems had a formal sex education curriculum. However, 12 of these school systems also had individual schools using "Postponing Sexual Involvement."

Larger school systems were somewhat more likely to be using the program than smaller school systems. Of the 46 school systems with two or more high schools, 22 (48%) were using the "Postponing Sexual Involvement" program in contrast to the 140 school systems with one high school or less where 43 (31%) were using the "Postponing Sexual Involvement" program. Also, city school systems (18 out of 27 [66%]) were more likely to be using the program than county school systems (56 out of 159 [35%]). However, geographic use of the program across the State seemed fairly evenly distributed. Twenty-nine percent of the school systems in the upper third of the State (19 out of 62) were using the program. Thirty-three percent of the systems located in the middle third of the state were using the program (24 out of 70). Thirty-nine percent of the school systems in the lower third of the state were using the program (21 out of 54).

Spontaneous comments made by school systems formally using the "Postponing Sexual Involvement" program were almost uniformly positive. Such reactions are reflected in comments such as:

"I think it's wonderful. Parents, kids, teachers respond to it well. Our board has adopted it for use at our school. We will use it every year!"

"I have thoroughly enjoyed this program. The kids really enjoy it, the feedback I get is great."

"We and the kids really love this



program. The response has been very positive. We feel it's very valuable."

Only two school systems reported any negative parental feedback to the program but indicated such feedback came from only a small minority of the parents. Sixty-two (62) school systems did not report any negative parental feedback.

### **How The "Postponing" Program Is Used**

Use of the "Postponing Sexual Involvement" program was varied. In over a third of the 64 schools using it, the survey could not determine in what part of the school curriculum it was being used. However, in the two-thirds where it was known, the two most mentioned places were Health/Physical Education (25) and Home Economics (15). One teacher commented that she was using the program in a parenting class for young mothers.

Of the school systems using the program, over two-thirds were using it in its entirety. Comments from those doing so included a teacher who said, "I enjoy it, the students seem to like it. I think it has made a difference." Another teacher commented, "The discussion that it sparks is an excellent tool." One school administrator said, "Lots of positive feedback from the students. I really like this program."

About a third of the school systems using the program were using only sections of it. This was in part explained by the range of youth to whom the program was being given. The program primarily was being used somewhere in grades 7 to 9. However, school systems using it with lower or upper grades often took just the applicable parts of the curriculum. For example, teachers using the program with high school students indicated that they were most likely to use the "peer pressure lines" and "assertive re-

sponses" sections. "The students enjoy the role modeling, the pressure lines are great." One school system uses the program intact with their 9th grade students in health, and then reinforces the program with the problem situations and pressure lines in the 10th and 11th grades.

Some school systems with existing family life education curriculum in place, also just took from the program those sections they felt blended with their existing program. Others commented that the time limitations prevented them from using the whole program.

Presentation of the program in some communities was a cooperative effort. In four communities, the program was presented in the schools by outside agencies. "The health department has doctors and nurses who teach the program." "The local hospital . . . has nurses and counselors who train 11th and 12th grade students from our school system to present the program to our 8th grade students." Teachers presenting the program in the schools in some instances also reached out to use it in the community. For example, one teacher said, "I use the 'Postponing Sexual Involvement' program with my students and personally with my church group. . . ."

Many of those who were using the program felt the results were positive. "This year my kids seem to be able to 'say no' more easily. I find this interesting. Maybe we're getting the message across." "I had a girl in the 11th grade in my office today who had the program in an earlier grade, and it's now helping her deal with peer pressure." "We've been fortunate enough to have an outside evaluation done on the effectiveness of the program for our highest risk students. It showed that although the program is only given in the 8th grade, it greatly reduced sexual involvement among such girls in both the 8th and 9th grades."

### **New Version of "Postponing Sexual Involvement"**

School systems surveyed also commented on the structure of the program. Although the majority of comments indicated satisfaction with the program the way it is, a few teachers did have some specific suggestions for changes. Comments particularly related to the slides used in the series, changing some and adding more, and to streamlining the last section on assertiveness. Based on the school survey, its own experience with the program, and comments received from users in other parts of the United States, the Emory/Grady Teen Services Program will be revising the "Postponing Sexual Involvement" program. Slides are being revised and new ones added, some parts of the program are being shortened and made to flow more smoothly. Also, the program is being packaged for five classroom length sessions. The new updated version is expected to be available for use in school systems by fall of 1988.

Finally, according to Marie Mitchell, R.N., Program Supervisor of the Emory/Grady Teen Services Program, new programs are on the way. "We have also applied for funds to develop a program for 5th and 6th graders. So many people have indicated that this younger age group needs something before the 'Postponing Sexual Involvement' program which was developed for those in 7th through 9th grades. Our 'Making Responsible Decisions' program we feel meets the needs of the older group. And of course our 'Discussion Guide on Human Sexuality' provides a good grounding for the middle and high school student in basic factual information." Ms. Mitchell indicated she hopes the program for 5th and 6th grade students will be ready for field testing during the coming school year. ■



# Preventing Youth Suicide: *We Can Make A Difference*

Iris Bolton

**A** 15-YEAR-OLD YOUTH may be speaking for hundreds of his peers when he wrote the following note:

War child,  
Peace Child . . .  
Falls inside himself  
Into a crevice of ungathered  
ends. . . .

Following the writing of this note, Jeffrey handed it to his English teacher, walked out of the classroom and into the boy's lavatory where he shot himself with a .38 caliber hand gun. Miraculously, he lived just long enough to say he did it because he "couldn't take it any more." His last words tried desperately to explain, "The pain just wouldn't go away . . . I'm a big fat zero . . . the loneliness . . . stupid . . . everybody's gonna be better off . . . I'm sorry . . ."

Young adults, adolescents, and children are choosing to die by suicide in increasing numbers. The rate has tripled in the last 2 decades and in many parts of the country is still on the rise. Suicide

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***Suicide is a  
community problem  
which requires a  
community solution.  
With that in mind, a  
number of concerned  
citizens have come  
together to form the  
Georgia Coalition for  
Youth Suicide  
Prevention.***

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is the third leading cause of death for youth under 19 years of age. Approximately 5,000 young people kill themselves annually, but it is estimated that the actual number of youth suicides is four times greater than reported. Studies show that 2 million high school students attempt suicide every year. Students, parents, and educators are asking "WHY?" Mental

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health professionals face the problem daily and struggle to find solutions. Ministers counsel young adults and youth from their congregations, only to preach at their funerals a few weeks later.

Youth suicide is a complex phenomenon which defies answers.

**W**hy a person will take his own life has baffled thousands of generations. Survivors of such a personal and family tragedy are just as puzzled today as survivors of 10,000 B.C. who lived in caves. Recent studies by sociologists, researchers, and suicidologists have focused attention on the subject, but the vast majority of us, almost totally uninformed about this issue, look on suicide as frightening and abhorrent. And all of us suffer deeply from guilt and grieving when it happens to us or our families.

Official data from the National Center for Health Statistics (1987) give the following statistics for 1985:

- Average of 1 person every 17.8 minutes killed themselves



- Average of 1 young person every 1 hour 37 minutes killed themselves
- 3.7 male completions for each female completion
- 5 million living Americans have attempted to kill themselves
- 3 female attempts for each male attempt
- Each suicide intimately affects at least 6 other people (Survivors)
- Based on the number of suicides since 1970, the number of survivors of suicide in the U.S. is 2.6 million and it is estimated that the number grows 180,000 each year! If there is a suicide every 17.8 minutes, then there are 6 new survivors every 17.8 minutes as well!!

**S**uicide is a community problem which requires a community solution. With that in mind, a number of concerned citizens have come together to form the Georgia Coalition for Youth Suicide Prevention. With the goal of finding ways to reduce the incidence of youth suicide in Georgia, the Coalition has established the following objectives:

1. To heighten public awareness of youth suicide and other self-destructive behavior.
2. To serve as a clearing house by acquiring, organizing and disseminating current information on youth suicide.
3. To facilitate communication and networking among other organizations with similar goals in the state of Georgia.

4. To encourage and support implementation of youth suicide prevention efforts.
5. To serve as advocates for local, state and national efforts regarding youth suicides.
6. To promote research on youth suicide.

The Coalition is composed of family members, public and private groups, mental health professionals, and welcomes participation by other interested groups.

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***We do not believe that the answer to the dilemma of how to prevent suicide rests in simplistic answers such as pathologically functional family systems, seriously emotionally disturbed youth, or genetic factors.***

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Anne-Clark, a psychiatric nurse in Atlanta, and a member of the Georgia Coalition succinctly expresses the philosophy of the group, as well as the thinking of some of the most knowledgeable people in the field.

"We want to clearly state a basic premise of our Coalition. That premise is that the phenomenon

of youth suicide is multi-faceted. No one causative factor can sufficiently explain or predict the event of suicide. Therefore, we do not believe that the answer to the dilemma of how to prevent suicide rests in simplistic answers such as pathologically functional family systems, seriously emotionally disturbed youth, or genetic factors. Instead, we view the event of youth suicide as a tragic phenomenon caused by some known factors and some unknown psychological and social factors. It is likely that social factors including socio-historical climate, cultural values, and societal integration hold the most promise in terms of explaining the phenomenon of suicide. Paradoxically, however, the decision to live or die rests largely with the individual."

"Our Coalition believes that a two-pronged effort is the best approach; that is, we believe that research and with attendant social policy implications for the larger scale cultural level is imperative. In addition, intervention on an individual and familial level must continue. A networking of concerned people armed with one another's knowledge can help to ameliorate the pain of youth suicide as well as to hopefully prevent the tragedy of losing more of our youth to untimely death." For more information regarding the Georgia Coalition for Youth Suicide Prevention, call The Link Counseling Center, 404-256-9797."





**First hundreds...**



**Then thousands...**

**Soon more than a million.**

Soon more than a million insulin users will be taking Humulin.


And no wonder. Humulin is identical to the insulin produced by the human pancreas—except that it is made by rDNA technology.

Humulin is not derived from animal pancreases. So it contains none of the animal-source pancreatic impurities that may contribute to insulin allergies or immunogenicity.

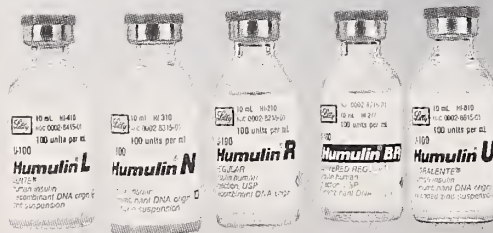
The clinical significance of insulin antibodies in the complications of diabetes is uncertain at this time. However, high antibody titers have been shown to decrease the small amounts of endogenous insulin secretion some insulin users still have. The lower immunogenicity of Humulin has been shown to result in lower insulin antibody titers; thus, Humulin may help to prolong endogenous insulin production in some patients.

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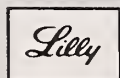
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# Rx for Tax Simplification

Linda Schwack Harrison, C.P.A.

**B**Y THE TIME YOU ENCOUNTER this dissertation, you will have most likely had your first exposure to the Tax Reform and Simplification Act of 1986 which is sometimes referred to as the most complicated and least documented tax law ever published in the history of the United States. To comprehend what the President, the Congress, and the Internal Revenue Service has bestowed on the taxpayers of our country, you have to think of your personal finances as being divided into three distinct, disjointed, and arbitrarily defined categories, whose only purpose is to join together to increase your "adjusted gross income" and ultimately, your income taxes.

First, and easiest to understand, is earned income — that which is begotten by the toil of the hand and the sweat of the brow. This segment of income was left untouched because it is already double taxed with income taxes and social security taxes. Categories two and three deal with the treatment of income that you receive from the investments you make with whatever earned income you have left after paying state and federal income taxes. Category two is still in the realm of easy comprehension. It deals with portfolio income, which is the new term for interest, dividends, and capital gains. Category three income is passive income. The concept of passive income was conceived as a vehicle to eliminate

the taxpayers incentive to invest in activities which generate tax losses. This form of investment, formerly known as tax shelters, allowed the taxpayer to deduct investment losses against earned income. Now income or losses from real estate partnerships, and S corporations in which you do not materially participate are considered passive income, or more usually, passive losses.

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***Interestingly enough, there are very few situations where the combination of the loss of deductions discussed above and the lower tax rates actually yield a lower tax liability for the taxpayer.***

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In order to get a maximum tax effect on you, the law abiding investor, the Congress decided not just to prevent other tax shelters from being formed, but to punish the investor who had taken full advantage of the tax law as it existed in the year of the investment. There is no "grandfather" provision to permit you to earn the benefits of the investments you made in passive activities prior to the enactment of the new law. You may, however, under the phase-in provision of the act, deduct 65% of your passive losses for 1987 for any investment you held as of October 22, 1986;

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40% of the losses in 1988; 20% in 1989; and 10% in 1990. In 1991, the deduction is totally eliminated except for real estate investments for people who materially participate in the management of the property and whose adjusted gross income, without considering the loss, is \$100,000 or less. The maximum allowable, deductible loss in this situation is \$25,000 which is reduced by 50% of the amount by which the taxpayer's adjusted gross income exceeds \$100,000. At \$150,000 it is therefore phased out.

Net losses from all passive activities in any 1 year are carried forward until such time as you divest yourself of the asset which has yielded the passive losses. Although the law limits your deduction for passive losses, it does allow you to add any non-deductible losses to the basis of your investment at the time the asset is sold. Therefore, upon the disposition of any investment you will have recouped any prior non-deductible losses. What all this translates to is the fact that you will no longer be able to deduct all of the expenses related to your real estate investments currently, and you will pay more tax. To help the taxpayer understand this section of the law, the Internal Revenue Service has issued the first 275 pages of regulations, with a promise of 500 additional pages in the future.

**D**eductions on your tax return for interest expense was the next casualty. Prior to the enactment of the new tax law, all consumer and mortgage interest was deductible. Currently, you may deduct the interest you pay on the mortgage on your primary and second home. The interest is deductible to the extent that your loan on the property does not exceed your initial cost plus the cost of improvements to the home. Interest on mortgages entered into after August 16, 1986, which exceed your basis in the property will be deductible if the proceeds of the loan were used for medical or educational expenses. It will be necessary to maintain very careful records in order to track the receipt of the mortgage loan and its disbursement for the designated expenses. As perhaps the greatest testimony to the fact that all of these regulations were unreasonably difficult for the taxpayer to comply with, on December 23, 1987, the Congress rewrote this section of the

law, with the new regulations to take effect for years beginning after December 31, 1987. These new provisions simply limit the deduction for mortgage interest on debt to acquire or substantially improve your principal or second residence up to the limit of \$1 million dollars. An additional deduction is available for interest on other debt, up to \$100,000, which is secured by your principal or second residence. Even with the liberalization of the law regarding the deductibility of mortgage interest, it has become increasingly more important to maintain good records detailing your expenditures for the improvements you make on your home throughout the years. It would probably be a good idea, if you haven't already done so, to sit down in the near future and create a home improvement file. Not only will this enable you to justify any future increase in your interest deduction, but it will enable you to establish your basis in the home at the time of its sale.

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***It is necessary to segregate the proceeds of any loans you may acquire in order to preserve their deductibility in the future.***

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Consumer interest which is interest payable on installment loans, charge card interest, and any other non-business related borrowing will be phased out on the same schedule as the phase-out that I discussed for passive losses above. For 1987, you were permitted to deduct 65% of your consumer loan interest. This provision encourages people to convert consumer interest into mortgage interest and will therefore help the mortgage industry. Loans to finance the purchase of an automobile will be subject to the deduction limitations, but if you have a home equity loan that doesn't exceed your basis in your home, the interest on the loan will be deductible as mortgage interest.



Prior to 1986, you were permitted to deduct an amount of investment interest equal to your investment income plus \$10,000. The \$10,000 will be phased out so that in 1987 your investment interest deduction is limited to your investment income plus \$6,500. This amount is reduced to \$4,000 in 1988, to \$2,000 in 1989, to \$1,000 in 1990, and zero thereafter. Investment income is income (less expenses) from property held for investment. Investment property produces income in the form of interest, dividends, annuities, or royalties not derived in the ordinary course of a trade or business. Gain or loss on the sale of property producing the aforementioned income is also investment income. Investment property also includes any interest in a trade or business activity which is not a passive activity and one in which the taxpayer does not materially participate. Any income or expense taken into account under the passive activity rules is not investment interest or expense. Interest expense on funds borrowed to acquire an interest in a passive activity will be considered under the passive activity rules and therefore subject to the passive activity limitations. Trade or business interest continues to be 100% deductible. Investment interest expense that is not currently deductible may be carried forward to future years.

**A**ll of these rules regarding the classification and deductibility of interest expense clearly illustrate the need to segregate the proceeds of any loans you may acquire so as to determine and preserve their deductibility in the future.

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***Interest expense on funds borrowed to acquire an interest in a passive activity will be considered under the passive activity rules and therefore subject to the passive activity limitations.***

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In view of the new rules on interest deductions and the deduction of rental activity losses, the question may come up as to the most advantageous way to handle the rental of a vacation home. Careful planning can potentially increase your overall deductions. To choose just one scenario, consider increasing the personal use of your va-

cation home to more than 15 days a year. This would necessitate apportioning the expenses of the home between rental and personal expenses. The mortgage interest that was apportioned to personal use would be qualified residence interest and would be fully deductible. The expenses allocated to the rental activity would then be netted against rental income. If the income exceeded the expenses, you would have passive income against which you could write off other passive losses. If the expenses exceeded the income from the rental, you would carry the expenses over to the next year. When the home is sold, the accumulated expense carry forward would increase your basis in the home, therefore reducing the gain or increasing the losses to be recognized. If your personal use of the vacation home is less than 15 days, the mortgage interest allocable to personal use would be consumer interest subject to the 65% limitation. All other expenses allocable to the rental activity would be netted against the income, and any loss resulting would qualify for the \$25,000 rental loss limitation if your adjusted gross income is \$100,000. During the phase in of the passive activity loss limitation, everyone can deduct the percentage of their loss as stated for the phase in years. Losses not used are carried forward as discussed above.

**J**ust in case you have managed to shelter some income, the alternative minimum tax is still in force. The rules are very complex and beyond the scope of this article except to highlight a few points. The alternative minimum tax rate was increased from 20% to 21% for 1987. To determine if you must pay alternative minimum tax, you start with your taxable income as calculated for regular tax purposes, and add back most of the deductions that you were permitted to take in the calculation of your regular taxable income. The resulting number is your alternative minimum taxable income. If you are married filing a joint return, you are entitled to a \$40,000 exemption. If you are single the exemption is \$30,000. The exemption for married filing separately is \$20,000. You then take the remainder and multiply it by 21% to determine your tentative minimum tax. If this amount is greater than your regular tax, you pay some additional tax. Careful planning with the aid of your tax professional will help to moderate this potential for increased taxes.



**D**uring the time that the Congress was debating this tax reform bill, the point that received most publicity was the reduction of tax rates. And true to their word, the number of tax brackets was reduced to five, so that the highest tax rate for 1987 is 38.5%. In 1986, there were 15 tax brackets, with the highest rate being 50%. The rates for individuals in 1988 will be even lower than the 1987 rates. Technically, income will be taxed at either 15% or 28% but because of the phase out of the 15% tax rate at \$43,150 for single taxpayers and at \$71,900 for married taxpayers, these middle income people will actually pay tax at an effective rate of 33%.

Interestingly enough, there are very few situations where the combination of the loss of deductions discussed above, and the lower tax rates actually yield a lower tax liability for the taxpayer. Even the simplest tax return with itemized deductions has been impacted by the loss of available deductions. The medical expense deductible has been raised to 7½% of the adjusted gross income. Unless you have major uninsured medical expenses or the tax law drives us all to seek psychiatric help, there will not be a medical deduction available. The deduction for sales tax is omitted entirely. Employee business expenses, which were formerly an adjustment to income, have now been reclassified as a miscellaneous itemized deduction unless your employer reimburses you for the expense. The deduction for miscellaneous itemized deductions is now limited to an amount that is in excess of 2% of your adjusted gross income. Therefore, this deduction is virtually eliminated for high income taxpayers.

**D**o you recall that the new tax law was supposed to take large numbers of people off of the tax rolls. The Internal Revenue Service now estimates that it will receive an additional 3.7 million tax returns from a heretofore neglected segment of the population — the children. The new “kiddie tax” will require many children who did not have to file tax returns under the old law, to file tax returns and to pay income taxes. The new law does not permit a person who can be claimed as a dependent on another tax return to take a personal exemption on their own return. If a dependent has \$1 or more of taxable interest, dividends, or other unearned income, and the total of that income plus any wages, or other earned income exceeds \$500,

they are required to file a tax return for 1987. Who says that the government ignores little children?

If the taxpayer is a child who is under 14 years of age and has unearned income of more than \$1,000, the child will pay tax at his parents' tax rate. One of the Internal Revenue Services 41 new forms was especially created to facilitate the calculation of the “kiddie tax.” Tax returns for children under 14 years of age cannot be prepared until you ascertain what their parents' tax rate is. In the case of divorced parents, the custodial parents' income is referred to in determining the child's tax rate. If a dependent has no unearned income, they do not have to file a tax return unless they have earned income of more than \$2,540.

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***The “kiddie tax” was designed to make it more difficult for parents to shift unearned income to their children and to pay tax at a lower rate. There are, however, some opportunities that are still available. . . .***

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The “kiddie tax” was designed to make it more difficult for parents to shift unearned income to their children and to pay tax at a lower rate. There are, however, some opportunities that are still available to permit you to shift income to your children at a lower tax rate. The tax rate for the first \$5,000 of income in a trust is still 15%. Income in excess of that is taxed at 28%. Establishing a trust with a minimum account balance of \$50,000 would yield enough low bracket income to make the extra expense of creating and administering the trust economical. The format of a minors trust permits the trustee, who could be the beneficiary's parents, to control the income and principal of the trust until the child becomes 21. At that time, if the child doesn't request the assets of the trust, the trust becomes a grantor trust, and the income of the trust is taxed to the child, while the trustee retains control of the assets. Periodic distributions of trust income to the child during the earlier years of the trust can be used for education expenses. If at this time, the child has attained the age of 14,



these distributions will be taxable to the child at his tax rates rather than at the parents' tax rates. An alternative to establishing a trust would be the purchase of a single premium annuity. An annuity purchased while the child is young will accumulate tax deferred income to provide for a child's education.

**F**iscal year or calendar year! Remember that controversy? It wasn't until December 23, 1987, that Congress made up its mind about that one. Personal service corporations were finally permitted to retain fiscal year ends if the employee-stockholder met certain salary requirements within the calendar year. But be careful, because for tax years beginning after December 31, 1987, personal service corporations will be taxed at a flat rate of 34%. The law also prohibits the carryback of a net operating loss from or to a year in which a personal service corporation elects to have a fiscal year. This means that you cannot pay tax 1 year, have a loss the next year, and receive a refund of the prior taxes paid. Accumulating money within your corporation will therefore be prohibitively expensive.

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***The deduction for miscellaneous itemized deductions is now limited to an amount that is in excess of 2% of your adjusted gross income. Therefore, this deduction is virtually eliminated for high income taxpayers.***

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If the new tax law has increased your taxes and made you depressed or confused you are not alone. The Internal Revenue Service anticipates that the error rate on tax returns will increase by 5.5 million and that adjustments will be made on an additional 2 million returns and 1.6 million balance due and overpayment notices will be issued. Think of all the time this will take and how tired they will be by the time they get around to you! ■

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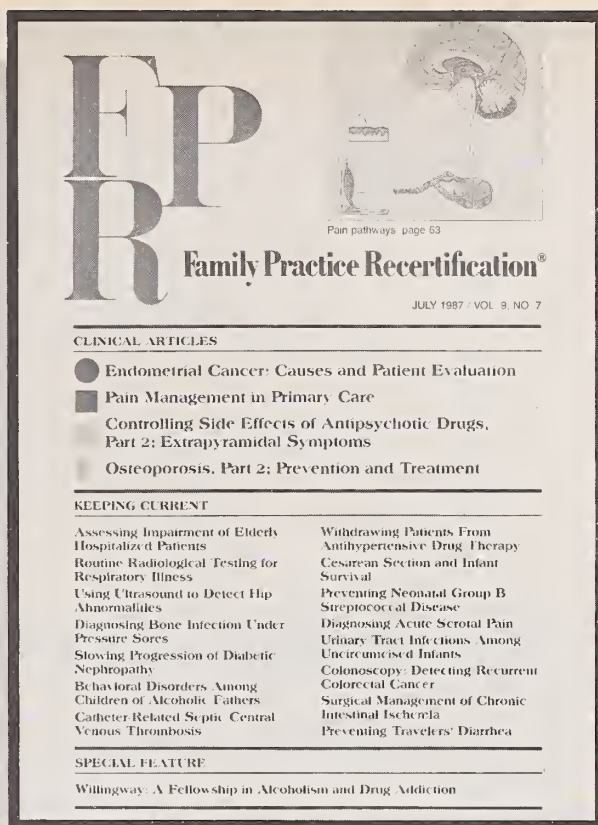
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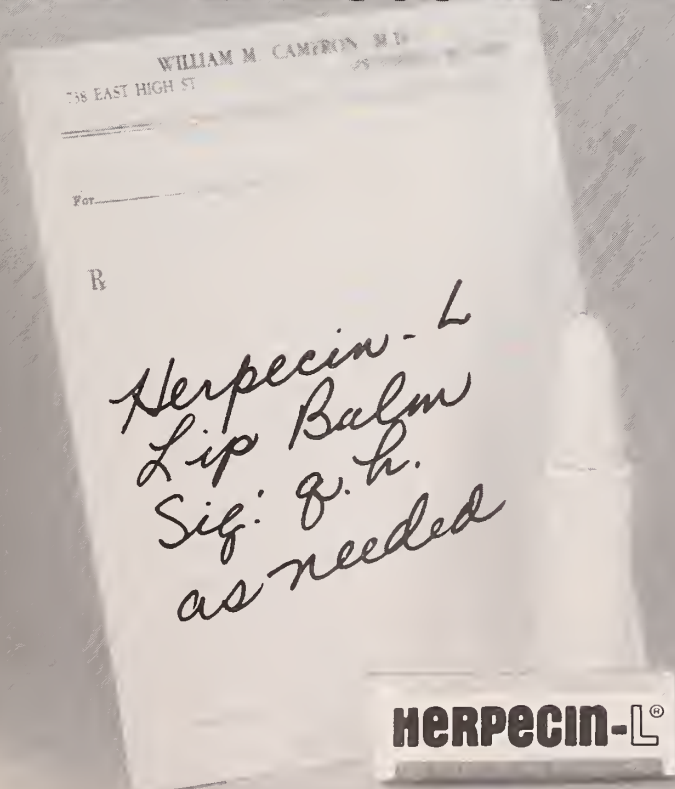
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# Have You Looked at Your Will Lately?

## Seven Common Mistakes in Estate Planning and How to Avoid Them

James S. Hutchinson

**“This article will focus on some of the most common (and damaging) errors in estate planning.”**

**I**T'S MONDAY. You are leaving this weekend for a skiing trip to Colorado. In thinking through all the last minute preparations, you also remember what you have been putting off for months — your Will. You've been thinking about updating it to change the guardians for your children or to get it current with the new tax law. You call your lawyer and get the Will patched up in a rush and then forget about it until vacation time rolls around again.

Sound familiar? Too many of us approach Wills and estate planning (if we get started at all) with such anxiety that planning is done in bits and pieces at the last minute. Yet even a minor amount of thoughtful attention to one's estate planning affairs can minimize estate taxes and insure that your family will be able to handle your estate with a minimum amount of trouble and expense.

This article will focus on some of the most common (and damaging) errors in estate planning. The first section will

focus on problems with the Will itself (or lack of one — e.g., the Will has been revoked unintentionally). The second section looks at common problems where the Will is fine but the property of the testator (the person making the Will) is not coordinated to work with the Will — thus nullifying the work that went into the Will. The final section reviews some common estate tax planning ideas that can save literally hundreds of thousand of dollars.

### Problems with the Will Itself

#### Mistake #1: You don't have a Will.

Many people who otherwise tend to their personal and business affairs responsibly simply cannot face having a Will drawn up for them. But this neglect can be a costly mistake. If you die intestate (without a Will), your “Will” is dictated by Georgia law, i.e., Georgia law determines who takes your property, and how. This often creates serious problems.

Consider a doctor who has a \$1.0 million estate. The doctor is married and has one young child. If the doctor wrote a Will, he might leave everything to his wife and

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further provide that if he and his wife died together the property would be held in trust for the child until the child reached a responsible age (e.g., 30 or 35). But if the doctor dies without a Will, the law provides that only one-half of the property goes to the wife. The other half goes to the child. Furthermore, the wife must hold the child's share as guardian for the child, which means annual reports to the Probate Court, significant restrictions on guardianship investments, and so on. Finally, and perhaps worst, the child's share must be turned over to the child at age 18, regardless of the child's maturity or ability to handle a large amount of money at that time.

An additional problem for doctors who die without a Will is that a doctor's professional practice, incorporated or otherwise, must be wound up after his death. If the doctor dies without a Will, the person who administers the estate is chosen by the Probate Court, and that person may not be who the doctor would have (and could have) chosen if a Will had been written. Clearly, the first step in thoughtful estate planning is

simply realizing that one must have a Will (and acting on that realization!).

*Mistake #2: The Will has been revoked unintentionally.*

Some people think they have a Will, but don't. Georgia law provides that a Will is automatically revoked upon the birth or adoption of a child, unless the Will specifically states that it stays in effect regardless of any such birth or adoption. This law has a good purpose — the law revokes Wills in this circumstance so that the testator dies "intestate" (i.e., without a Will) and the new child will receive a share of the estate. However, by revoking the entire Will automatically, the law leaves many people who thought they had a Will without one, and this can lead to serious problems such as those discussed under Mistake #1 above.

A person who has children and may have more in the future can avoid this automatic revocation simply by stating in his or her Will that the Will shall not be revoked by the birth or adoption of a child. If this is done, care should also be taken to write the Will so that it

will "expand" automatically to include future children.

Other events can cause an unintentional revocation. For example, a Will is automatically revoked by marriage or divorce. An awareness of this rule (and, again, acting on it to have a new Will drawn to reflect the testator's new circumstances) will avoid trouble and expense for one's family later on.

*Mistake #3: A Will executed in another state is not reviewed for compliance with Georgia law.*

Georgia is still attracting "immigrants" from other states. Those who move here often have Wills that were drawn up on the state they left, but they do not have those Wills reviewed to make sure that they work well under Georgia law. Failure to have a Will review session can cause problems.

For example, many states require Probate Court inventories, appraisals and accountings as part of the estate administration process. In Georgia, on the other hand, a testator in his Will can relieve the executor from virtually all day to day contact with the Probate Court in administering an



estate. If the Will does not contain these "reliefs" for the executor worded in the proper way, it will mean delays, hassles, and legal expenses when death occurs.

As another example, many Wills name a bank as an executor under a Will, and, like most states, Georgia generally allows only Georgia banks to serve as the executor of a Georgia decedent's estate. Therefore, the executor clause should be reviewed carefully to determine its suitability in Georgia.

#### **Improper Coordination of Property with the Will**

*Mistake #4: You have a well-drawn Will, but your property is held in a manner so that it passes outside the Will and renders the Will useless.*

Let's say you have been conscientious and have had a Will drawn up. The Will sets up trusts for your spouse and children for tax and other purposes. However, your house is held with your spouse as "joint tenants with right of survivorship," which means that upon your death the house passes to your spouse automatically regardless of what your Will says. Your brokerage account is held jointly with your spouse, titled the same way. And of course, some or all of your bank accounts are held jointly with your spouse.

What happens at your death? All of the joint survivorship property passes, automatically by reason of law, outside of your Will to your spouse (assuming she survives you). None of the joint property is

added to your so-called "probate" estate (i.e., the property that your Will controls), and thus none of the property passes into the trusts which you carefully set up in the Will. The thoughtful planning which you did in your Will is distorted because your property was not properly coordinated with your Will.

***“... Even a minor amount of thoughtful attention to one's estate planning affairs can minimize estate taxes and insure that your family will be able to handle your estate with a minimum amount of trouble and expense.”***

A similar problem often occurs with insurance. It is not uncommon for a person to set up a careful scheme of trusts in his Will but not realize that his insurance beneficiary designations must be coordinated with the Will. Insurance proceeds pass through your "probate" estate only if you have named your estate as the beneficiary of the insurance proceeds (or if the policy so

provides); if you have named someone other than your estate to be the beneficiary of the insurance proceeds, those proceeds will pass to that person regardless of what the Will says.

This is not to suggest that a person should avoid holding property in joint names with right of survivorship or that all insurance on one's life should be payable to one's estate. In many circumstances, it will make sense to hold certain property in joint names or to name one's spouse (or others) as the direct beneficiary of life insurance proceeds. The point is that if your estate plan will work only if certain property passes under your Will, then be sure that it happens!

*Mistake #5: Improper coordination of estate plan with retirement plan death benefits.*

In 1984, Congress enacted the Retirement Equity Act, which, among other things, created dramatic new death benefit rights for spouses of participants in pension and profit sharing plans. Under virtually all pension and profit sharing plans, the spouse now has the right to all or a significant part of the benefit payable under the plan in the event of the participant's death, unless the spouse waives that right under certain formal procedures.

How does this affect the estate plan? To begin with, it reduces the flexibility that a plan participant has in planning his or her estate. For many doctors, their pension and profit sharing plans represent an enormous portion of their net



worth, and because of the Retirement Equity Act, decisions concerning the disposition of the plan benefits upon the doctor's death must now be made jointly by the doctor and his or her spouse.

Furthermore, failure to fully understand the new law can result in a distorted estate plan. Consider the example of a married doctor who prior to 1984 had named his estate as the beneficiary of his pension and profit sharing accounts in the event he died before retirement. He did this so that the plan assets would pass through his Will and into certain trusts for his wife and children. The new law, however, overrides those beneficiary designations, and will result in at least half and perhaps all of his plan assets passing to his wife in the event of his death prior to retirement. This may pass outright to the wife a large amount of money which the doctor wished to leave in trust, and it could also distort the distribution scheme in favor of the wife.

The lesson here is to be aware of the effect of the new law on one's estate plan and to take the law into account in deciding on a distribution scheme.

#### Tax Planning

*Mistake #6: Not taking full advantage of the \$600,000 estate tax exemption.*

Under current federal estate tax law there is an unlimited estate tax deduction for property which passes to a decedent's surviving spouse, which means that one can have an estate of millions of

dollars and, if one leaves it all to one's spouse, there will be no estate tax until the spouse's subsequent death.

What is the most common error in estate tax planning? Look at the words above: "there will be no estate tax *until the spouse's subsequent death.*" Many persons hear about the unlimited marital deduction and think that the estate tax problem is solved by leaving all of one's property to the spouse. But this can result in a significant and in many cases completely avoidable estate tax at the spouse's death.

***“Many persons hear about the unlimited marital deduction and think that the estate tax problem is solved by leaving all of one's property to the spouse. But this can result in a significant and in many cases completely avoidable estate tax at the spouse's death.”***

To understand why this is so one must also understand that under current estate tax law each spouse can leave up to \$600,000 to

persons other than the surviving spouse and pay no estate tax whatsoever. One common strategy in estate planning is to make sure that one uses both \$600,000 exemptions (one for each spouse), so that up to \$1.2 million is left with no estate tax to one's descendants or other beneficiaries when both spouses are gone.

How is this done? The typical method is to have the first spouse to die leave up to \$600,000 not to the surviving spouse outright, but rather to an "estate tax shelter trust" in one's Will. If created properly, this \$600,000 is not subject to estate tax in the estate of the first spouse to die; it is available for the support of the surviving spouse during her lifetime; and, because of certain minimal restrictions in the trust, the property in the trust is sheltered from estate tax at the surviving spouse's death.

Consider the following example: Doctor A has an estate of \$1.0 million. His Will leaves it all to his wife outright. There is no estate tax at Doctor A's death because all of his property passes to his wife and qualifies for the estate tax marital deduction. However, look at the result when the wife dies (a short time later, let's assume). She has her own \$600,000 exemption, but that still leaves \$400,000 subject to estate tax. The amount of the estate tax is \$153,000.

Doctor B also has an estate of \$1.0 million, but his Will leaves \$400,000 outright to his wife and the other \$600,000 to an estate tax shelter trust for the benefit of his wife and children. At Doctor B's



death, the \$600,000 which passes to the trust is covered by his \$600,000 estate tax exemption, and the \$400,000 passing to the wife is covered by the marital deduction — therefore, no estate tax at Doctor B's death. Upon the wife's death, the \$600,000 in the trust is sheltered from estate tax and the \$400,000 held by the wife in her own name is fully covered by her own \$600,000 estate tax exemption — therefore, no estate tax at the wife's death either. Through the intelligent use of both spouses' estate tax exemptions, Doctor B passed his full \$1.0 million estate to his children and paid zero estate tax.

*Mistake #7: Not taking advantage of estate tax planning with life insurance.*

Under current federal estate tax law, one can often obtain estate tax savings of hundreds of thousands of dollars through proper transfers of life insurance. These transfers are especially tax-effective with term life insurance (with no cash value element).

How is this done? Most commonly it is done by having the doctor create an "irrevocable life insurance trust" and then assigning the ownership of the insurance to the trust during the doctor's lifetime. If the doctor lives for 3 years after the transfer is made to the trust, and if the trust is properly designed, then the life insurance should be sheltered from estate taxation at the doctor's death; the insurance proceeds are available for the support of the doctor's spouse and children during the

surviving spouse's lifetime; and the insurance proceeds should be sheltered from estate tax at the surviving spouse's death. Furthermore, if the insurance transferred to the trust has no cash value, then there is no gift tax when the policy is transferred to the trust during the doctor's lifetime.

How valuable is this planning technique? Think about it this way. How much term life insurance do you have on your life right now? If you hold on to the life insurance during your lifetime and have it paid to your spouse at your death, the estate tax on the insurance proceeds at your surviving spouse's death will begin at a marginal rate of 37% if your spouse's taxable estate exceeds \$600,000 (or \$1.2 million if you have avoided Mistake #6 above).

Using these assumptions, the estate tax on \$500,000 in life insurance proceeds before the proceeds pass down to the children could be upwards of \$185,000 ( $37\% \times \$500,000$ ). Since a term life insurance policy is worth nothing to you during your lifetime, the case for putting the policy in an irrevocable insurance trust can be compelling.

There are complexities in setting up an irrevocable insurance trust and, because the trust is irrevocable (it cannot be changed once set up), there are circumstances where it will not be appropriate. However, for someone who has a significant amount of life insurance, it is a mistake to not explore the tax planning possibilities.

### Conclusion

Death and taxes may be inevitable, but we don't like to think about them. Nevertheless, the professional who has a proper Will, properly coordinates his property with his Will, and at least considers some basic estate tax planning steps is doing his family a priceless service. ■



It is the light of the laser. And the miracle it is performing in the medical world. At DeKalb General, this remarkable tool has taken the form of Laser Lithotripsy, an alternative to percutaneous or transurethral lithotripsy procedures to fragment stones in the middle and upper ureter. The major advantage to the procedure is the reduced risk of damage to the ureteral wall. The procedure itself delivers a pulsating laser beam through a microscopic, flexible fiber directly to the stone. It can be viewed through a miniaturized scope. Often, it can be

## DEKALB GENERAL HAS SEEN THE LIGHT.

administered on an outpatient basis. Laser lithotripsy may be utilized on most stones in any part of the urinary tract. Or it may be used to complement what will be another new addition at DeKalb General in June, Extra-Corporeal Shock Wave Lithotripsy (ESWL), which uses externally generated shock waves on the stone

to fragment it. Shock wave lithotripsy, significantly more costly than laser, is best limited to stones occurring in the kidney or upper third of the urinary tract. With the emphasis on outpatient, DeKalb General offers the CO<sub>2</sub> Laser Surgery, which seals lymphatics and nerve endings as it cuts, reducing post-operative edema, pain, bleeding, and surgical time. At DeKalb General, CO<sub>2</sub> procedures are used mainly for GYN, urology and general surgery. On a more general basis, the procedure is used for breast resections, tumor excisions, debridement, endometriosis, pelvic adhesions and genital wart virus. A new process using the CO<sub>2</sub> Laser is operative laparoscopy, which allows surgeons to perform complex intrapelvic procedures through a scope, without requiring a large incision. The YAG Laser is used by urologists for bladder tumors; by gynecologists for endometrial ablation; and by gastroenterologists for obstructive lesions, polyps or strictures of the GI tract. DeKalb General's Magnetic Resonance Imaging (MRI) will become available later this year in the new Diagnostic Imaging Center. MRI represents a significant step forward in diagnostic imaging. Its capability for the central nervous system goes well beyond CT imaging for the head and spine. An advantage over CT is that MRI does not utilize ionizing radiation. The technology is constantly improving: cardiac imaging and evaluation of joint spaces and abdominal soft tissue are now clinically applicable.



DE KALB GENERAL HOSPITAL

AN AFFILIATE OF SOUTHCARE<sup>SM</sup> MEDICAL ALLIANCE AND VHA.



## 1987 — A Year of Transition for the ACS

Thomas W. Phillips, M.D.

**“New York had become too expensive. The national leadership found that the cost of operating the world’s largest voluntary health agency in New York City was escalating at a tremendous rate.”**

### National Moves to Atlanta

**T**HE ENTHUSIASM of American Cancer Society volunteers and the commitment of Atlanta community leaders made possible two of the Society’s major accomplishments in 1987: after 75 years in New York City, the National Headquarters of the American Cancer Society is moving to Atlanta; and the Georgia Division dedicated the Cecil B. Day Building as its new State Central Office. The generosity and hard work of hundreds of dedicated Georgians, and particularly the medical communities, brought to fruition these great achievements.

The Georgia Division has always been a national leader in cancer control. Even so, 1988 will see a greater alliance between the Georgia Division and the National Society. The National move to Atlanta will enhance our resources and give us an unprecedented opportunity to share our commitment to cancer control internationally.

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*This paper was sponsored by the Georgia Division of the American Cancer Society. Those wishing to contribute papers to this Section should send them to Thomas W. Phillips, M.D., CANCER Section Editor, at the above address.*

On September 1, 1987, the National Board of Directors met in Chicago to make a decision that had become one of the hottest debated issues in the 75 years of the Society’s existence. The question — where can the American Cancer Society function most effectively and provide the best stewardship of the public’s contributed dollar?

New York had become too expensive. The national leadership found that the cost of operating the world’s largest voluntary health agency in New York City was escalating at a tremendous rate. Funds that could have been earmarked for cancer research and program development were being expended to meet the rapidly inflating costs of the National Office. In addition, the Society was having difficulty attracting experienced field staff to New York.

The National Board of Directors recognized the need to broaden the experience of the national staff by including more members who have worked at the grass roots level of the Society. In a background paper prepared for the Board of Directors by consultants and staff, the need to recruit experienced Field Staff is viewed as “second in importance only to the need to maximize the contributor’s dollar. . . .”



# C A N C E R



*Breaking ground last February for the new national headquarters for the American Cancer Society are (L to R): **G. Robert Gadberry**, Executive Vice President of the American Cancer Society (ACS); **Frederick Hilgorne Talbot**, Bishop, A.M.E. Church; **Harmon J. Eyre, M.D.**, President, ACS; **Kay Horsch**, Chairman of the Board, ACS; Georgia's Governor **Joe Frank Harris**; **Manuel Maloof**, CEO of DeKalb County; and **Dr. James T. Laney**, President of Emory University.*

**I**n November of 1986, an ad hoc committee was appointed to study the possibility of relocating out of New York City. The charge of the committee was to identify where the Society could best function in the context of economics and affordability. In addition, the committee would consider what effect the selection would have on the Society's image and ability to function within the needs of volunteers and staff. Almost immediately, over 100 cities began vying for the opportunity to become the new home of the

American Cancer Society. The list of 100 was quickly narrowed to 14 cities. Four became the leading contenders: Atlanta, Dallas, Houston, and New York City.

In Atlanta, Georgia Division volunteers and leaders from the business community and government began mobilizing their resources to present the best possible package to the relocation committee and Board of Directors. Led by two members of the medical community, Dr. A. H. Letton and Dr. LaMar McGinnis, this coalition of concerned citizens

pulled together a team that became the motivating force behind the eventual decision to select Atlanta. Meeting weekly — and some weeks, daily — the committee began the task of creating an incentive package that would lure the Society to Atlanta. Annie Hunt Burris of the Georgia Department of Industry and Trade became the main person coordinating the committee's efforts. The city became excited about the possibility of hosting the world's preeminent health agency. Business, professional, and civic



interests began lining up to help. The spirit that had made Atlanta the undisputed leader of the South gave us the competitive edge over the competition.

**A**fter weeks of hard work, dozens of meetings, and hundreds of phone calls, the committee finally had a package. The Robert W. Woodruff Foundation in cooperation with Emory University provided the needed incentives. The Woodruff Foundation made available 4.5 acres of prime real estate across from the Centers for Disease Control near the Emory University campus. In addition, the Woodruff Foundation promised a grant of \$1 million to help defray the cost of moving from New York to Atlanta. The grant, combined with the gift of land, brought the total package to \$3.5 million. Emory University School of Medicine offered to share many services, including the medical library and epidemiologic support. Emory offered the Society the opportunity to merge its (the Society's) 13,000 volume collection of medical literature with Emory's 178,000 volume collection. In addition, it would allow the Society's scientists library privileges and the opportunity to have a terminal in the American Cancer Society Headquarters linked to the main library computer for online research. Emory also agreed to build a hotel conference center adjacent to the new American Cancer Society headquarters site to provide 300 hotel rooms and adequate meeting and convention facilities for ACS volunteers.

***“The grant, combined with the gift of land, brought the total package to \$3.5 million. Emory University School of Medicine offered to share many services, including the medical library and epidemiologic support.”***

The Centers for Disease Control, which is located directly across from the Woodruff site, graduates 70 epidemiologists per year and offered its services to assist during the transition period. This will certainly allow a cooperative atmosphere between American Cancer Society and the Centers for Disease Control.

The committee had the package, but the battle was far from over.

During the summer, additional cities began putting together very attractive packages. In June, the National Site Selection Committee, meeting in Dallas, decided to expand the search to include more cities.

Meanwhile, the Georgia committee continued to sell Atlanta and search for additional incentives. On August 12, 1987, the national site selection committee was reconvened. During that meeting, it was decided that the city of Atlanta would best serve as

the location *if* the Board decided to move from New York City. It had boiled down to New York versus Atlanta. There was intense lobbying on all sides, but on September 1, 1987, while meeting in Chicago, the National Board of Directors of the American Cancer Society decided that Atlanta was the logical choice. The Board based its decision on five major factors:

- economics
- how the location will function as a ACS Headquarters
- community attractiveness
- acceptability to volunteers and staff
- assessment of future consequences.

Atlanta won out on all issues. The Board voted 74 to 14 to bring the world's largest volunteer health agency with its prestige, 300 employees, \$21 million operating budget, \$275 million in bank deposits, and hosts of volunteers and scientists to Atlanta.

Construction on the 155,000 square foot National Headquarters Building began in February, 1988, with anticipated occupancy in January of 1989. In April of 1988, the Society will be relocating to temporary offices at Tower Place on Peachtree Street and will be fully based in Atlanta by July 1.

## **The Georgia Division Finds a New Home**

**T**he same commitment and dedication that brought the National American Cancer Society



to Atlanta was also responsible for providing the Georgia Division a new home. The Cecil B. Day Building, the Georgia Division's new Central Office Building, was dedicated at the Division's Annual Meeting in October. The purchase of the building located at 46 Fifth Street in downtown Atlanta was made possible through a capital funds campaign which brought together many of the same participants that had made Atlanta the new home of the National Cancer Society. With over 15,000 square feet of space, the new building is 60% larger than the leased space that the Division previously occupied. It is estimated that the purchase of the Day Building will save over \$125,000 per year in lease payments. This savings coupled with the new facility will provide the much needed space to implement new programs.

## Services of the Society and the Georgia Division

**A**lready in operation is the American Cancer Society's Cancer Answer Line. The Cancer Answer Line provides a statewide toll free information hotline to answer the public's questions about cancer. The system is an effective way of meeting the information and support needs of cancer patients and their families by providing an easy access toll free telephone number. The Answer Line addresses such issues as cancer prevention and early detection, as well as giving non-medical information about cancer

sites, treatment, and research.

A major thrust of these services will be a peer support system for patients and their families which will be staffed by volunteers who have cancer or who have recently recovered from cancer. A simplified information system will also alleviate much of the public's confusion concerning "Look-a-Like" organizations whose materials are designed to resemble those of the American Cancer Society.

**T**he Georgia Division's Childhood Cancer Program addresses the very special needs of children with cancer. An expanded program will provide for a support and guidance network of trained volunteers who will be able to assist families who are facing childhood cancer. The newly formed childhood cancer committee is addressing issues that include hospice, psychologic impact on long-term survivalship, and education and information networks. Currently, this program reaches 150 juvenile cancer patients and their families per year. The Division estimates that through our expanded efforts we can easily double that capacity, thereby potentially serving all of Georgia's children with cancer.

**C**hanges in the health care system will make it imperative that we work closely with hospitals and other health care organizations in order to provide education and service to the general public and to cancer patients. We will develop a pilot hospital-based American Cancer

Society program in three areas of the Division. This will enable us to expand our presence in the community by reaching out with our Service Program through volunteers. Once completely organized, our full spectrum of services will be made available to the patient in the hospital setting.

We know that the poor have a high cancer mortality rate, higher than others due to late diagnosis associated with socio-economic problems. Our obligation is to reach out to this population with our educational and service programs. We know that the mammogram will detect breast cancer early and save lives. We are now challenged with the ways and means to insure that all women have access to this detection technique. A task force will be formed this year to develop strategies to address this issue. The task force will be composed of members of our Professional Education, Public Education, and Public Information committees.

**1**987 has been a year of transition, a year of change. "Show me an organization that's not changing and I'll show you an organization that's not growing," a well used management statement which is certainly not applicable to the American Cancer Society. Change will mean progress to both the National Society and to the American Cancer Society in Georgia. The result: more lives saved, additional funds for research and a cohesive committed corps of volunteers dedicated to eliminating cancer. ■



## *Pulmonary Hypertensive Disorders and the Arachidonic Acid Metabolites*

*Dan McKenney, M.D.*

**“Research indicates that arachidonic acid metabolites may play major roles in the pathology and progression of pulmonary vascular diseases. It is enticing to consider that there is perhaps a common ingredient that ties these diseases together.”**

**P**ULMONARY VASCULAR HYPERTENSION or pulmonary vascular obstructive disease (PVOD) encompasses several diseases of varying etiologies, including persistent pulmonary hypertension of the newborn, PVOD secondary to left-to-right shunts in congenital heart disease, primary pulmonary hypertension, and pulmonary hypertension of chronic hypoxia. Drug treatment for each of these is less than optimal, and these conditions are often irreversible. Recent research has focused on the pathophysiology of pulmonary vasoconstriction and vasodilatation in the hopes of perhaps finding a final common pathway for some of these diseases. Eventually, drugs may be available which can either simulate or be used to manipulate endogenous vasoactive compounds to help prevent, arrest the progression, or definitively treat these conditions. Ideally these

drugs should be selective with minimal systemic effects. The most promising research has been centered on the arachidonic acid metabolites: prostaglandins (especially prostacyclin), thromboxanes, and the leukotrienes.

### **Arachidonic Acid Metabolites**

#### *Prostaglandins*

The prostaglandin prostacyclin is a cyclooxygenase product of arachidonic acid metabolism produced by the pulmonary vascular endothelium.<sup>1</sup> Although in adults, prostacyclin is a systemic and pulmonary vasodilator, in children it has been shown to be a relatively specific pulmonary vasodilator.<sup>2</sup> In addition to its vasodilatory properties, prostacyclin has a direct inhibitory effect on DNA synthesis and reduces platelet aggregation. Released in response to hypoxia, shear stress, thrombin and platelet factors, prostacyclin may mitigate the progressive structural and vasoconstrictive effects of these factors on the vascular endothelium.<sup>3,4</sup> In its inhibition of DNA synthesis, prostacyclin may

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also help to mitigate the vascular changes (i.e., intimal hyperplasia) which are associated with chronic hypoxia.<sup>4</sup> Chronic hypoxia, however, results in decreased endothelial cell production of prostacyclin, perhaps paving a way for the progression of these changes. Also, because it has platelet anti-aggregatory properties, prostacyclin may interfere with vessel wall damage caused by exposure of basement membranes and collagen to shear stress or other nonspecific inflammation.<sup>3-5</sup> Studies show that prostacyclin infusion reduces pulmonary vascular tone and hypoxic vasoconstriction with minimal side effects, suggesting a possible role for prostacyclin in the treatment of pulmonary vascular hypertensive disorders. In particular, it has been shown to be beneficial in children with congenital heart disease, children in pulmonary hypertensive crises, and in reducing the hyperreactivity of the pulmonary vasculature (and therefore, perhaps decreasing further damage) in children with Eisenmenger syndrome.<sup>2</sup> Currently, it must be given intravenously in an ICU setting and its use, for the most part, is experimental. In the future,

however, it may be used alone or in conjunction with other therapies in treating these conditions.

#### *Thromboxanes*

The thromboxanes, also products of the cyclooxygenase pathway of arachidonic acid metabolism, are the antithesis of prostacyclin.<sup>1</sup> They are potent vasoconstrictors of the pulmonary vascular smooth muscle, promote platelet aggregation, and may play an active role in pulmonary vascular diseases with vasoconstrictive or inflammatory components.<sup>6,7</sup> They are elevated in pulmonary hypertension induced by Group B Strep in proportion to the increase in severity of pulmonary vascular resistance.<sup>7</sup> They also may play an important role in pulmonary vasoconstriction induced by hypoxia or vascular endothelial injury. Studies of thromboxane inhibition in animals have yielded mixed results, possibly secondary to species variation and the confounding effects of other arachidonic acid products.<sup>6</sup> In studies of patients with primary pulmonary hypertension who had elevated circulating levels of thromboxanes, thromboxane inhibition resulted in

decreased pulmonary vascular resistance and prolonged survival in some patients.<sup>8</sup>

#### *Leukotrienes*

The leukotrienes are a group of endogenous chemicals derived from arachidonic acid through the lipoxygenase pathway.<sup>5</sup> Leukotrienes are known to cause systemic and pulmonary vasoconstriction and certain of these (especially LTD<sub>4</sub>) are more selective for the pulmonary circulation.<sup>9,10</sup> They have been isolated from lung lavage fluid in patients with persistent pulmonary hypertension of the newborn syndrome and adult respiratory distress syndrome and are released in response to hypoxia in the early part of the endotoxin response.<sup>3,11</sup> They have been proposed as mediators in the pulmonary vasoconstriction of these disorders.<sup>3,5,12</sup> It has also been suggested that leukotrienes (i.e., LTC<sub>4</sub>) in conjunction with a low pO<sub>2</sub>, help maintain the high pulmonary vascular resistance of the fetal circulation.<sup>3</sup> Hypoxia may induce the endothelium to release leukotrienes which then act as effectors on the smooth muscle of the small pulmonary arteries



resulting in constriction.<sup>3</sup> Leukotrienes C4 and D4 are major components of the slow reacting substance of anaphylaxis, suggesting a possible role for these compounds in the inflammatory reaction within the pulmonary vasculature leading to vasoconstriction.<sup>1, 10, 12, 13</sup> The action of the leukotrienes are complex in that, in addition to a possible direct vasoconstrictive effect, the slow reacting substance of anaphylaxis has been shown to enhance the release of vasoconstrictor prostaglandins and thromboxane A2.<sup>12, 13</sup> Leukotriene antagonists have been demonstrated to mitigate hypoxia-induced vasoconstriction in animal studies, although results have appeared to be species-dependent.<sup>12</sup> Research is underway to establish those diseases in which leukotrienes play a role and to study the possible therapeutic role of the leukotriene antagonists.

**I**t becomes clear in reviewing the literature that the physiologic roles of the arachidonic acid metabolites are complex and varied as are the pulmonary vasoconstrictive diseases. But research indicates that these metabolites may play major roles in the pathology and progression of pulmonary vascular diseases. It is enticing to consider that there is perhaps a common ingredient that ties these diseases together. Perhaps this common tie is the nonspecific inflammation which occurs in many of these conditions, i.e. hypoxia induced

injury to the vascular endothelium or the endothelial injury secondary to shear stress which occurs in high flow left-to-right shunts in children with congenital heart disease.<sup>3</sup> As arachidonic acid metabolites have been implicated in the inflammatory response and in the conditions described, the manipulation of these metabolites may become a substantial component of the treatment of these conditions. Research is in progress to elucidate the part the arachidonic acid metabolites play in the pulmonary hypertensive disorders and the possibility that prostacyclin or antagonists of leukotrienes and thromboxanes may be useful in their treatment.

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**Slow-K<sup>®</sup>**  
potassium chloride  
slow-release tablets  
8 mEq (600 mg)

It means "dependability" in almost any language

\*Based on worldwide sales data on file, CIBA Pharmaceutical Company.  
Capsule or tablet slow-release potassium chloride preparations should be reserved for patients who cannot tolerate, refuse to take, or have compliance problems with liquid or effervescent potassium preparations because of reports of intestinal and gastric ulceration and bleeding with slow-release KCl preparations.

Before prescribing, please consult Brief Prescribing Information on next page.



# The World's Most Popular K

## For good reasons

- **It works**—a 12-year record of efficacy<sup>1</sup>
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- **It's comparable to 10 mEq**—in low-dosage supplementation<sup>3†</sup>
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**Slow-K<sup>®</sup>**  
potassium chloride  
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For patients who can't or won't tolerate liquid KCl.

\*The most common adverse reactions to potassium salts are gastrointestinal side effects.

†Pooled mean serum potassium following oral administration of 30 mEq K-Tab compared to 24 mEq Slow-K in diuretic-treated hypertensives (n = 20) over 8 weeks.

## C I B A

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**Slow-K<sup>®</sup>**  
potassium chloride USP  
Slow-Release Tablets  
8 mEq (600 mg)

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE INSERT)

### INDICATIONS AND USAGE

BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.

1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure; hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function; potassium-losing nephropathy; and certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

### CONTRAINDICATIONS

Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see OVERDOSAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

### WARNINGS

**Hyperkalemia** (See OVERDOSAGE).

In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

### Interaction With Potassium-Sparing Diuretics

Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

### Gastrointestinal Lesions

Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

### Metabolic Acidosis

Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

### PRECAUTIONS

#### General:

The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

#### Information for Patients

Physicians should consider reminding the patient of the following:

- To take each dose without crushing, chewing, or sucking the tablets.
- To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.
- To seek with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.
- To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

#### Laboratory Tests

Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

#### Drug Interactions

Potassium-sparing diuretics: see WARNINGS.

#### Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in animals have not been performed.

#### Pregnancy Category C

Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

#### Nursing Mothers

The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

### Pediatric Use

Safety and effectiveness in children have not been established.

### ADVERSE REACTIONS

One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

### OVERDOSAGE

The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 ml/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

### DOSAGE AND ADMINISTRATION

The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

**Note:** Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

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A JOURNAL FOR CARDIOLOGISTS AND  
PHYSICIANS IN INTERNAL MEDICINE

VOL 5 NO 1 • JANUARY 1988

- ▲ Effect of Medical versus Surgical Therapy for Coronary Disease / PETER PEDUZZI, PhD, et al.
- ◆ Electrophysiological Testing and Nonsustained Ventricular Tachycardia / PETER R. KOWEY, MD, et al.
- ▲ Residual Coronary Artery Stenosis after Thrombolytic Therapy / LOWELL F. SATLER, MD, et al.
- ◆ Assessment of Aortic Regurgitation by Doppler Ultrasound / PAUL A. GRAYBURN, MD, et al.
- ▲ Embolic Risk Due to Left Ventricular Thrombi / JOHN R. STRATTON, MD
- ◆ Hemodynamic Effects of Diltiazem in Chronic Heart Failure / DANIEL L. KULICK, MD, et al.
- ◆ Cardiovascular Reserve in Idiopathic Dilated Cardiomyopathy / RICKY D. LATHAM, MD, et al.
- ▲ Overview • Coronary Angioplasty: Evolving Applications / GEORGE W. VETROVEC, MD

\*Journals reviewed include: *Circulation*, *American Heart Journal*, *Journal of the American College of Cardiology*, *British Heart Journal*, *Chest*, *The American Journal of Cardiology*, *The New England Journal of Medicine*, *Annals of Internal Medicine*, *American Journal of Medicine*, and *The Journal of the American Medical Association*.



## **PHYSICIANS, SCHEDULE SOME TIME FOR YOUR COUNTRY.**

Many physicians would like to devote some time to their country in a local Army Reserve unit. We know that making a weekend commitment can be difficult for most physicians. So it is practical for the Army Reserve units to be flexible about time. It's worth discussing.

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To find out about the benefits of serving with a nearby Army Reserve unit, we recommend you call our Army Medical Personnel Counselor.

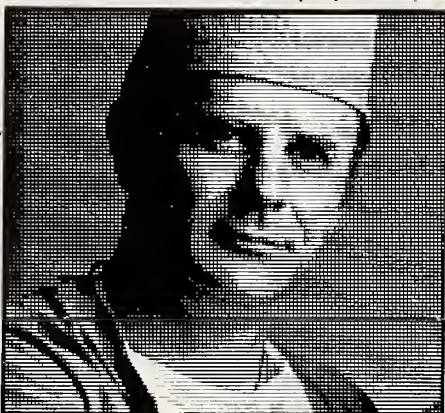
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## HAIKU

*Winter branches hide  
Beauty in their barrenness;  
leaves will bud in spring.*

*Be not deceived by  
Birdsong, warm breezes, sunshine;  
Winter is not gone.*

*Baby birds are captive  
in the nest, until one day  
they learn to fly.*

*Dull brown crinkled leaves  
Cling stubbornly to branches  
Primed for spring's rebirth.*

*Another day dies  
And life is that much shorter;  
Love that much richer.*

*Outside my window  
Sun sparkles on sand and sea  
And children playing.*

RUTH S. INGLIS

## THE NATURE OF THINGS

*People pass but rarely meet,  
People talk but rarely hear;  
Alone in the midst of conversation  
Alone in the crush of a busy street.*

*And the soul cries out, "I have love to give!"  
But who has time to hear the cry?  
Who has time to accept the gift  
The soul must offer if the soul would live?*

*Moments occur, transitory, fleeting,  
Love given and received, two souls meeting,  
Reality unveiled the moment brings!  
Rare of necessity; do not rebel.  
Learn to accept it's the nature of things.*

RUTH S. INGLIS

In, *VOICES: The Art and Science of Psychotherapy*

## RETROSPECT

*No longer do I love you  
as I did when love was new;  
When life was full of springtime —  
we were young — and cares taboo.  
No longer can I love you  
as I did in summertime —  
When foliage was full blown  
and our love was in its prime.  
No longer could I love you  
when the frost came on the dew —  
Mem'ry fanned the autumn fires  
with the flame I felt for you.  
No longer may I love you  
as the seasons change again;  
To thaw the blast of winter —  
I'll remember — now and then!*

RUTH S. INGLIS

## UNSEEN

*The soul blossoms quietly;  
The soul grows invisibly;  
As it acquires humility,  
A gift that only God can see.*

RUTH INGLIS

## INSIDE OUT

*You cleared my sight that I might see;  
You touched my soul that it might be.  
The door of love you opened wide,  
Inviting me to come inside.  
Leaving behind both fear and doubt  
I learned to love from inside out.*

RUTH S. INGLIS

*Ruth Inglis (Mrs. Ervin Peter, Jr.) is a member of the Cobb County Medical Auxiliary.*



## Physician's Recognition

LISTED BELOW are those physicians in Georgia who have earned the AMA's Physician's Recognition Award (PRA) from July through December, 1987.

The Award was established by the AMA House of Delegates in 1968 "to recognize, encourage, and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a 3-year period to qualify for the Award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored for Category I credit by organizations accredited for these activities.

We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Emile G. Abbott, Conyers  
William Earl Adams, Columbus  
Dogan Aktunc, Martinez  
Amarasinghe Amarasinghe,  
Augusta  
David Lloyd Anders, Augusta

Kenya Houghton Anders, Augusta  
Mohammad Arshad, Forest Park  
Philip Bates Bailey, Dalton  
Thomas W. Bantly, Tucker  
Steven Richard Barker, Atlanta  
John Baynard Baxley, Augusta  
Merrill Berman, Smyrna  
Douglas Ronald Bess, Atlanta  
Alberto Italo Bonasera, Norcross  
Otoniel Moises Boudet,  
Milledgeville  
David Morton Boyette, Albany  
Stephen Boyle, Conyers  
Danny Joe Bramlett, Thomaston  
Homer Breckenridge, Donalsonville  
Larry Bregman, Atlanta  
Robert Allen Brigham, Augusta  
Grail Lee Brookshire, Martinez  
Alan Keith Brown, Savannah  
George Washington Brown,  
Palmetto  
Jimmy Sheppard Brown, Norcross  
Rodney Mack Browne, Macon  
James R. Burns, Gainesville  
David Emerson Burtner, Macon  
Jack Allison Butler, Unadilla  
John A. Buxton, Calhoun  
James Andrew Campbell, Fitzgerald  
Charles Irving Caulton,  
Milledgeville  
Miriam W. Chambless, Hamilton  
Sy-Ru Chiang, Tifton  
Cyrus Michael Cioffi, Atlanta  
George Donald Clarke, Savannah  
Grady S. Clinkscales, Atlanta  
Thomas Andrew Cochran,  
Columbus  
Robert Ted Cook, Chatsworth  
William W. Coppedge, Atlanta  
Jose Fernando Cordero, Atlanta  
Wayne N. Darville, College Park

Harry Nathaniel Davis, Canton  
Hernando DeSoto, Augusta  
Eloy Edilberto Diaz, Riverdale  
David Peter Drotman, Atlanta  
Richard E. DuBois, Atlanta  
William Cross Dudley, Columbus  
Marshall Finley Eidex, Decatur  
Taher Abdel El Gammal, Augusta  
Dean Cook Elliott, Augusta  
Warren D. Elliott, Savannah  
Richard Shafter Field, Augusta  
Alfonso C. Findley, Smyrna  
Robert Merrill Fine, Atlanta  
Edwin E. Flournoy, Albany  
Mauro Folgosa, Riverdale  
Carlos M. Franco, Decatur  
Ned Martin Franco, Atlanta  
David Jay Frolich, Macon  
Henry Frysh, Marietta  
William A. Futch, Conyers  
Arvind M. Gadhia, Bowdon  
Paul Jason Glass, Atlanta  
Robert T. Goetzinger, Forest Park  
Raul Alberto Gonzalez, Rome  
Michael Cowl Gordon, Smyrna  
William Lee Graham, Columbus  
Herbert S. Greenwald, Macon  
Mack Varnedoe Greer, Valdosta  
Joe Leonard Griffeth, Commerce  
Donald Lewis Griffin, Tifton  
Samuel Charles Griffin, Athens  
Ross F. Grumet, Atlanta  
Gregory Scott Harold, Perry  
William F. Harper, Albany  
Lewis B. Hasty, Atlanta  
Muhammad Hawasli, East Point  
Raleigh R. Haynes, Tifton  
Donald Jay Heyboer, Dublin  
Hobart C. Hortman, Rome  
William Slocum Howland, Atlanta  
John Harris Hunt, Statesboro



## ward Recipients

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Anthony Frank Isele, Albany  
Eugene Hooks Jackson, Hahira  
Salley Sue Jessee, Atlanta  
Allyn C. Johnson, Gainesville  
C. Denton Johnson, Columbus  
Grady Hugh Johnson, Dublin  
J. Sherwood Jones, Dalton  
Lawrence Ralph Jones, Augusta  
Mary Bernadean Jones, Nicholls  
Randy L. Judd, Atlanta  
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A. Paul Keller, Athens  
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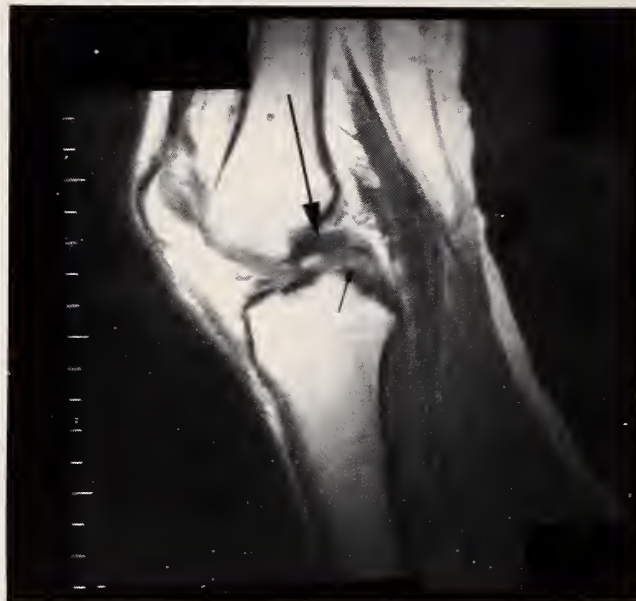
# MR UPDATE

## MRI Advances the Detection of Musculoskeletal Disease

### KNEE EXAMINATION

**HISTORY:** This 44-year-old female recently sustained a knee injury and has clinical evidence of abnormal laxity of the posterior cruciate ligament.

**SCAN:** This parasagittal view near the midline clearly demonstrates avulsion of the posterior cruciate ligament (large arrow). The ligament is normally attached at its femoral origin. Total avulsion of the ligament has occurred near its tibial insertion, the expected position of which is marked by the small arrow. The higher intensity (lighter) material at the tip of the small arrow represents hemarthrosis consequent to the recent injury.



**MRI HIGHLIGHTS:** The ligamentous structures of the knee are routinely well demonstrated by surface coil MRI. Surface coil imaging is essential for the special resolution needed in this area. Surface coil MRI is also useful for demonstrating meniscal injuries. Frank meniscal disruption may be seen and confirmed at arthroscopy. Since the articular surfaces, bone detail, and extra-articular structures are also shown by MRI, MRI is highly competitive with contrast arthrography. MR requires no painful injection and no ionizing radiation. MRI is also the procedure of choice for imaging aseptic necrosis of the hip and other musculoskeletal diseases.



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Sorter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. *N Engl J Med* 1976;294:687-90.

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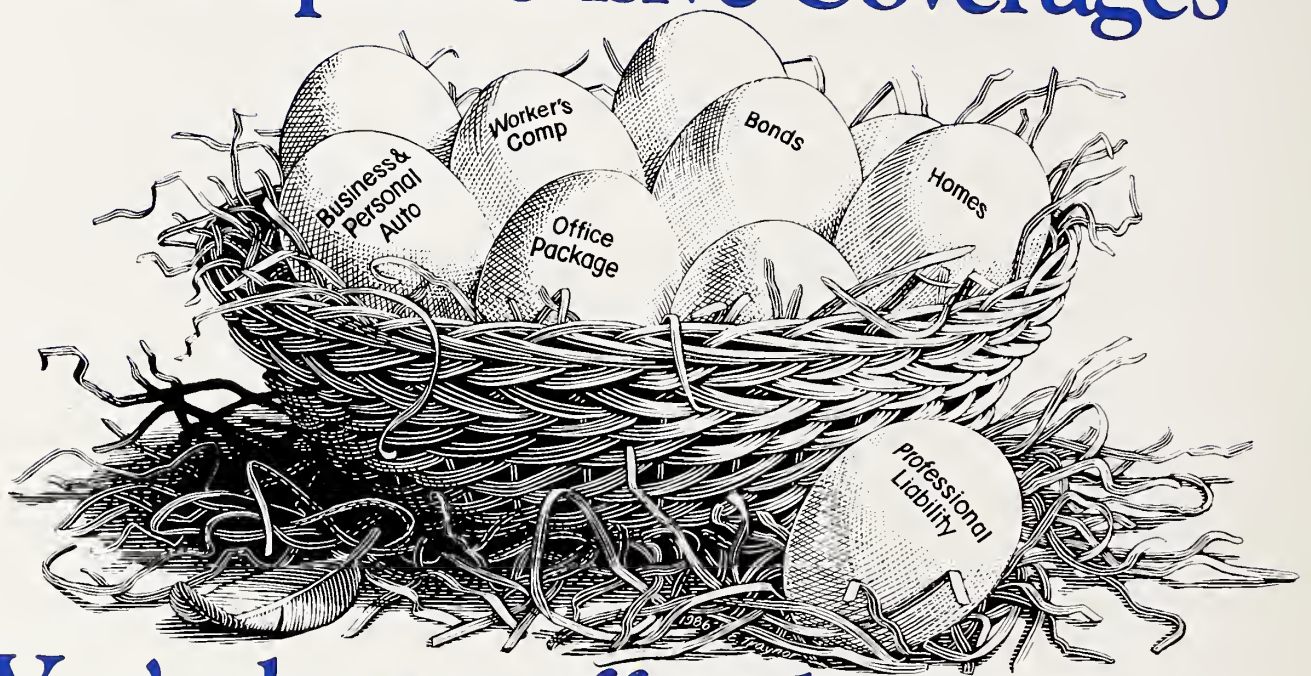
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THE ATYPICAL MYCOBACTERIA  
NEONATAL PNEUMOCOCCAL PNEUMONIA  
SUBCLAVIAN TO CAROTID ARTERY BYPASS  
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**COVER**

"Life is short, the art long. Timing is exact, experience theatrical, judgment difficult" is the rather unlikely title of this month's cover art by New York artist Yun James Yohe. Mr. Yohe's paintings are shown exclusively at Eves Mannes Gallery at Tula, 75 Bennett St., Suite 2B, Atlanta 30309; 404-351-6651. See p. 281 for more discussion of this gifted artist's work.

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

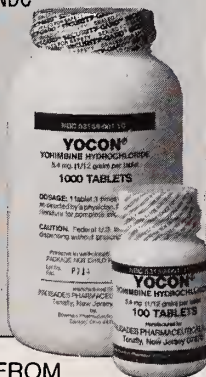
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis, in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2. For the prevention of potassium depletion when the dietary intake is inadequate in the following conditions: Patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, and with certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

**CONTRAINDICATIONS:** Potassium supplements are contraindicated in patients with hyperkalemia since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: Chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene).

Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to enlarged left atrium.

All solid dosage forms of potassium chloride supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation.

**WARNINGS: Hyperkalemia**—In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic. The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

**Interaction with Potassium-Sparing Diuretics**—Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene) since the simultaneous administration of these agents can produce severe hyperkalemia.

**Gastrointestinal Lesions**—Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage or perforation.

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**Metabolic Acidosis**—Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, potassium acetate, or potassium gluconate.

**PRECAUTIONS:** The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis per se can produce hypokalemia in the absence of a deficit in total body potassium while acute acidosis per se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium. The treatment of potassium depletion, particularly in the presence of cardiac disease, renal disease, or acidosis requires careful attention to acid-base balance and appropriate monitoring of serum electrolytes, the electrocardiogram, and the clinical status of the patient.

**Laboratory Tests:** Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

**Drug Interactions:** Potassium-sparing diuretics; see **WARNINGS**.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** Long-term carcinogenicity studies in animals have not been performed.

**Pregnancy Category C:** Animal reproduction studies have not been conducted with K-DUR. It is also not known whether K-DUR can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. K-DUR should be given to a pregnant woman only if clearly needed.

**Nursing Mothers:** The normal potassium ion content of human milk is about 13 mEq per liter. Since oral potassium becomes part of the body potassium pool, so long as body potassium is not excessive, the contribution of potassium chloride supplementation should have little or no effect on the level in human milk.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS:** One of the most severe adverse effects is hyperkalemia (see **CONTRAINDICATIONS**, **WARNINGS**, and **OVERDOSAGE**). There have also been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see **CONTRAINDICATIONS** and **WARNINGS**); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

**OVERDOSAGE:** The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see **CONTRAINDICATIONS** and **WARNINGS**). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration and characteristic electrocardiographic changes (peaking of T-waves, loss of P-waves, depression of S-T segment, and prolongation of the QT-interval). Late manifestations include muscle-paralysis and cardiovascular collapse from cardiac arrest.

Treatment measures for hyperkalemia include the following:

1. Elimination of foods and medications containing potassium and of potassium-sparing diuretics.  
2. Intravenous administration of 300 to 500 mEq of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml.

3. Correction of acidosis, if present, with intravenous sodium bicarbonate.

4. Use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia, it should be recalled that in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

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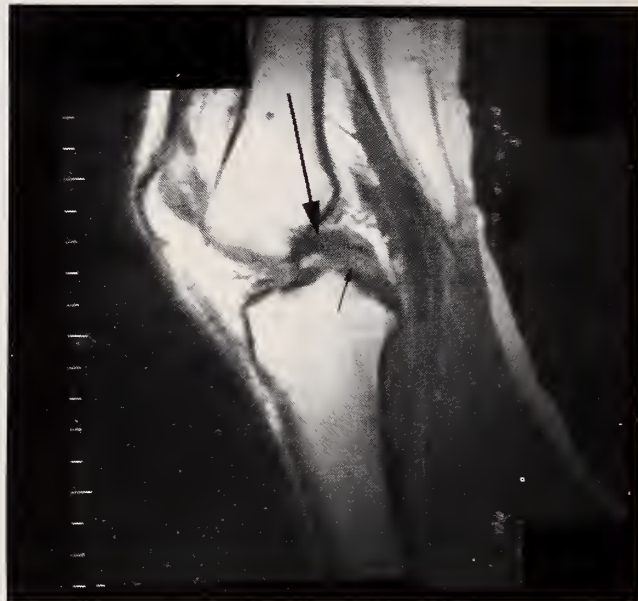
# MR UPDATE

## MRI Advances the Detection of Musculoskeletal Disease

### KNEE EXAMINATION

**HISTORY:** This 44-year-old female recently sustained a knee injury and has clinical evidence of abnormal laxity of the posterior cruciate ligament.

**SCAN:** This parasagittal view near the midline clearly demonstrates avulsion of the posterior cruciate ligament (large arrow). The ligament is normally attached at its femoral origin. Total avulsion of the ligament has occurred near its tibial insertion, the expected position of which is marked by the small arrow. The higher intensity (lighter) material at the tip of the small arrow represents hemarthrosis consequent to the recent injury.



**MRI HIGHLIGHTS:** The ligamentous structures of the knee are routinely well demonstrated by surface coil MRI. Surface coil imaging is essential for the special resolution needed in this area. Surface coil MRI is also useful for demonstrating meniscal injuries. Frank meniscal disruption may be seen and confirmed at arthroscopy. Since the articular surfaces, bone detail, and extra-articular structures are also shown by MRI, MRI is highly competitive with contrast arthrography. MR requires no painful injection and no ionizing radiation. MRI is also the procedure of choice for imaging aseptic necrosis of the hip and other musculoskeletal diseases.



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# ON

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## **INDERAL LA is their preferred beta blocker**

...of the nearly three out of four physicians responding to the questionnaire, an impressive 97% rated **INDERAL LA** good to excellent for overall performance. Virtually all cited efficacy, tolerability, long-term cardiovascular protection and once-daily convenience as important factors in their choosing to prescribe **INDERAL LA**.

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# The one you know best keeps looking better

Please see next page for brief summary of prescribing information.

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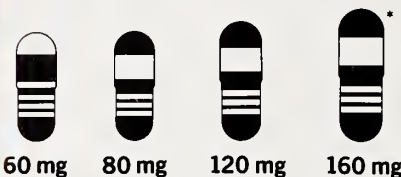


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LONG ACTING CAPSULES  
60, 80, 120, 160 mg

The one you know best  
keeps looking better



BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

#### INDERAL<sup>®</sup> LA brand of propranolol hydrochloride (Long Acting Capsules)

**DESCRIPTION.** Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

**CLINICAL PHARMACOLOGY.** Inderal is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by Inderal, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

Inderal LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with Inderal LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of Inderal Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

Inderal LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to Inderal LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, Inderal LA has been therapeutically equivalent to the same mg dose of conventional Inderal as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure, and rate pressure product. Inderal LA can provide effective beta blockade for a 24-hour period.

**INDICATIONS AND USAGE.** **Hypertension:** Inderal LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. Inderal LA is not indicated in the management of hypertensive emergencies.

**Angina Pectoris Due to Coronary Atherosclerosis:** Inderal LA is indicated for the long-term management of patients with angina pectoris.

**Migraine:** Inderal LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

**Hypertrophic Subaortic Stenosis:** Inderal LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. Inderal LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

**CONTRAINDICATIONS.** Inderal is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with Inderal.

**WARNINGS.** **CARDIAC FAILURE:** Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

**IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE,** continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or Inderal should be discontinued (gradually, if possible).

**IN PATIENTS WITH ANGINA PECTORIS,** there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of Inderal therapy. Therefore, when discontinuance of Inderal is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If Inderal therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute Inderal therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

**Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS.** Inderal should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

**MAJOR SURGERY:** The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

**INDERAL (propranolol HCl),** like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

**DIABETES AND HYPOGLYCEMIA:** Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

**THYROTOXICOSIS:** Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing  $T_4$  and reverse  $T_3$ , and decreasing  $T_3$ .

**IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME,** several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

**PRECAUTIONS. GENERAL:** Propranolol should be used with caution in patients with impaired hepatic or renal function. Inderal (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that Inderal may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

**CLINICAL LABORATORY TESTS:** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

**DRUG INTERACTIONS:** Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if Inderal (propranolol HCl) is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure, or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, phenobarbital, and rifampin accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and lidocaine have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected  $T_3$  concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

**CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY:** Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

**PREGNANCY:** Pregnancy Category C. Inderal has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. Inderal should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**NURSING MOTHERS:** Inderal is excreted in human milk. Caution should be exercised when Inderal is administered to a nursing woman.

**PEDIATRIC USE:** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS.** Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

**Cardiovascular:** Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

**Central Nervous System:** Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

**Gastrointestinal:** Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

**Allergic:** Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

**Respiratory:** Bronchospasm.

**Hematologic:** Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

**Auto-Immune:** In extremely rare instances, systemic lupus erythematosus has been reported.

**Miscellaneous:** Alopecia, LE-like reactions, psoriasisiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

**DOSAGE AND ADMINISTRATION.** Inderal LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from Inderal Tablets to Inderal LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. Inderal LA should not be considered a simple mg-for-mg substitute for Inderal. Inderal LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

**HYPERTENSION—Dosage must be individualized.** The usual initial dosage is 80 mg Inderal LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

**ANGINA PECTORIS—Dosage must be individualized.** Starting with 80 mg Inderal LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

**MIGRAINE—Dosage must be individualized.** The initial oral dose is 80 mg Inderal LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, Inderal LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

**HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg Inderal LA once daily.**

**PEDIATRIC DOSAGE—**At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

\*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

#### Reference:

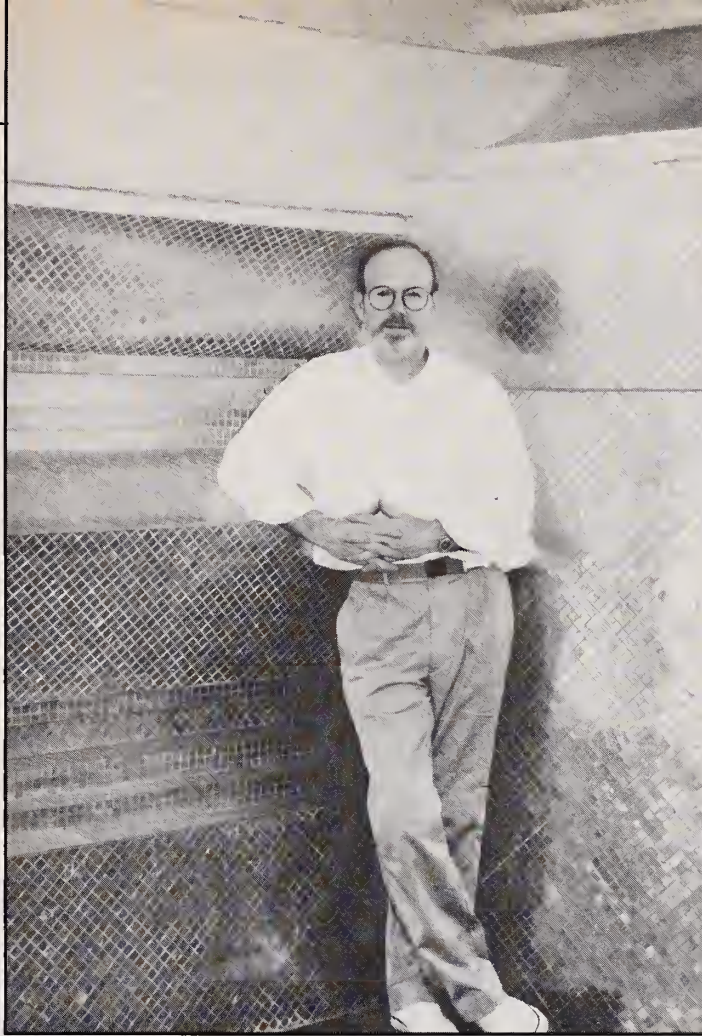
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## About the Cover Artist

# Yun James Yohe

**Y**UN JAMES YOHE's painting has steadily concerned itself with bringing contemporary Western and ancient Eastern idioms of abstraction and philosophy into balance.

A painter since childhood, Yohe was born in San Francisco in 1944 and raised in Saudi Arabia. After completing his basic education in Switzerland, he returned to America and obtained a bachelor of fine arts degree from the University of New Mexico in 1968 and a master's degree from Rutgers in 1972.

Although he is not Oriental, despite the sound of his name (Yohe is of German origin), he has adopted the aesthetic Oriental ideal of contemplation as the basis for his life and his art. One does not so much look at one of his paintings as enter

into a meditation on it. "With a conscious and definite Orientalism," he has created "an art that can lead to thoughts about other things. I've always felt my images were not so much abstract as associative," he says.

Mr. Yohe's paintings reveal themselves slowly. Each time one finds something that was not there before. His titles are fragments of poems and prose, such as that used on this month's cover: *Life is short, the art long. Timing is exact, experience theatrical, judgment difficult.*

Mr. Yohe's paintings are shown exclusively in Atlanta at EVE MANNES GALLERY at Tula, 75 Bennett St., Suite 2B, Atlanta 30309. PH: 404-351-6651.

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## On Team Work

***‘Is quality of health care at an affordable price as opposed to quality health care at any price the question we must answer? Do these queries represent the dilemma we face?’***

**I**T COMES AS NO SURPRISE to anyone conversant to even a modest degree with American medicine that the cost of health care in the Republic is on the rise. When a third party payor, known for its capability through the years to provide health insurance, finds it necessary to raise its annual rates 50% for that coverage, then the critical nature of the matter looms ominously before both patient (consumer) and physician/hospital (provider). One dare not take undue refuge or consolation in the knowledge that the luxuries of their lives, and yes, their essentials, be it food or housing or clothing, are evermore costly. For we deal in our profession with one of the indispensables of a person's existence. And, with one of the indispensables concerning which we have always prided ourselves that there is but one grade of quality. Shoes and suits may offer one the choice of good, better, or best, but in care of the sick and injured there must be, or so we would espouse, but one manner in which to treat a child with pneumonia, a woman with a troubled pregnancy, a man with a malignancy. That way must be the best that skill and technology allow.

“Oh,” you say, “foolishness!” We all know that levels of care exist — levels dictated by one's locale, by

one's ability to select competent physicians, or by the adequacy of available hospital facilities. No doubt these are indisputable facts of our lives. No one can deny that across the state and nation there ranges a wide array of quality in the health care field.

But cost — the price of the product — must that be an indispensable part of the equation? The matter lies at the heart of that eternal argument over universal health care insurance — at the heart of the argument concerning the *right* to health care. It is the driving force propelling the chilling prospect of socialized medicine. From that concern our adversaries draw their sustenance.

I would propose to you the simplistic suggestion that it is a problem to be solved only when the players in the game set their mind to solve it.

**W**hen a hospital, known for its dedication to quality care, becomes obsessed with its bottom line and launches into ventures bringing it into conflict with and invading the field of interest of its medical staff with those ventures far afield from the primary task, *then* the problem will not be solved. When a state legislature, out of lack of knowledge or fixed on personal gain, loses sight of the goal and with reckless abandon



puts into law statutes mandating payments and health care modalities themselves generating second class care at inflated prices, *then* the problem will not be solved. When third party payors fail to understand and take seriously the obligation which they have assumed, losing sight of quality health care as a mission and not the means to an investor's gain, *then* the problem will not be solved. When physicians lose sight of their heritage and launch themselves into the commercial arena in such a manner as to adversely impact their hospital's profit margin with the tattered and ethically questionable excuse of, "I have as much right to enjoy the income as the hospital does," *then* the problem will not be solved.

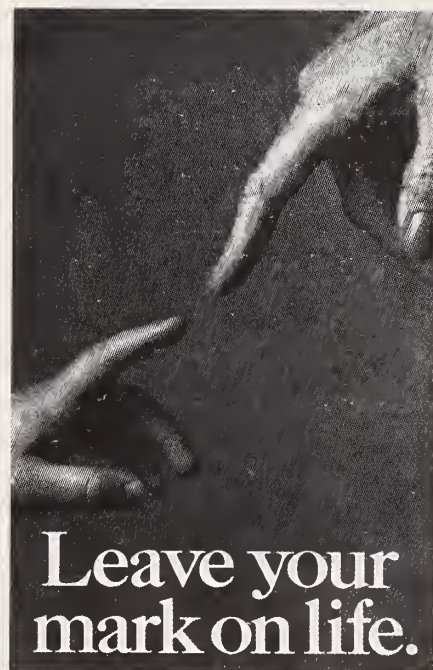
Wherein lies the answer? Can we afford the medical care that lies ahead at the cost which at present seems unavoidable? Certainly we can. *But*, we must be willing to dispense with some, perhaps many, of those parts of our lives which to now we have judged to be inviolate. I speak not only of physicians but also of the public of this nation. They, too, must place quality health care ahead of the luxuries of their lives. Is "quality health care at an affordable price" as opposed to "quality health care at any price" the question we must answer? Do

these queries represent the dilemma we face? The answer, of course, eludes us.

**I** would suggest that we must engage these problems and the future with the attitude of the sparrow described by Herman Talmadge found one day lying upon its back attempting to balance the entire world on his spindly legs. To the person suggesting that he was far too small to manage such a load, the bird replied, "One does what one can." There is only so much we as individual physicians can do. But, we *can* be knowledgeable of the problem. We *can* pay more attention to "quality" as a non negotiable and to "cost" as an unavoidable bed person. We *can* refuse to be part of the commercialization of health care. We *can* monitor that portion of the expenditure of the health care dollar which falls within our control and not shy away from the responsibility of educating our peers concerning the part which they must play. And we *can* insist that we be part of the team while at the same time insisting that the other players recognize their unique position in the effort. Only then will the heritage we are heirs to be truly and deservedly ours. Only then can we sleep in the quiet comfort of knowing that

here, in this place and at this time, with honest application of talent and effort did we do our part. ■

CRU



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# CALENDAR

## MAY

28-29 — *Sea Island: Georgia Neurosurgical Society*. Category 1 credit. Contact Herman Flanigin, M.D., Secy-Treas., MCG, Augusta 30912. PH: 404/828-3071.

## JUNE

3-4 — *Macon: Cancer Management Course*. Category 1 credit. Contact James T. Evans, M.D., Mercer Univ. Sch. of Med., 777 Hemlock St., Macon 31208. PH: 912/744-1367.

10-12 — *St. Simon's Island: Daily Anesthetic Challenges*. Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

13-18 — *Kiawah Island, SC: Internal Medicine Symposium*. Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

17-19 — *Savannah: GAFF CME weekend*. AAFP Prescribed & AMA Category 1 credit. Contact Ga. Acad. of Fam. Phys., 3760 LaVista Rd., Ste. 100, Tucker 30084. PH: 404/321-7445.

23-26 — *Sea Island: Georgia Chapter of the American Academy of Pediatrics Spring Meeting*. Contact Executive Secretary William Mankin, 4059 Land O'Lakes Dr., Atlanta 30342. PH: 404/237-3922.

## JULY

11-13 — *Kiawah Island, SC: Clinical Obstetrics*. Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

14-16 — *Kiawah Island, SC: Update in Gynecology*. Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

19-23 — *Kiawah Island, SC: Critical Care Medicine*. Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

25-27 — *Kiawah Island, SC: Pediatric Update*. Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

## AUGUST

8-12 — *Destin, FL: Summer Imaging and Interventional Techniques VI*. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

11-14 — *Amelia Island: Georgia Psychiatric Summer Meeting*. Category 1 Credit. Contact James Moffett, MAG, 938 Peachtree St., Atlanta 30309. PH: 404/876-7535 or 800/282-0224.

15-19 — *Atlanta: A Comprehensive Board Review in Internal Medicine*. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

26-28 — *Kiawah Island, SC: Georgia Society of Anesthesiologists/South Carolina Society of Anesthesiologists Meeting*. Contact William Hammonds, M.D., 1365 Clifton Rd., Atlanta 30322. PH: 404/321-0111.

## SEPTEMBER

2-4 — *Callaway Gardens: Georgia Society of Internal Medical/Georgia Chapter, American College of Physicians/Georgia Gastroenterologic Society Joint Meeting*. Category 1 credit. Contact James Moffett, 938 Peachtree St., Atlanta 30309. PH: 404/867-7535 or 800/282-0224.

15-17 — *Sea Island: Georgia Surgical Society*. Category 1 Credit. Contact William C. McGarity, M.D., 1365 Clifton Rd., NE, Atlanta 30322. PH: 404/321-0111.

19-20 — *Atlanta: Menopause Today*. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH: 404/727-5695.

14-16 — *Atlanta: Advances in the Rx and Dx of Cardiovascular Diseases*. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH: 404/727-5695.

14-16 — *Savannah: Neonatology — the sick newborn*. Category 1 credit. Contact Div. of Cont. Ed., Augusta 30912. PH: 404/721-3967.

22-24 — *Hilton Head Island, SC: Frontiers in Nutrition*. Category 1 credit. Contact Div. of Cont. Ed., Augusta 30912. PH: 404/721-3967.

28-29 — *Atlanta: Georgia Chapter of the American Academy of Pediatrics Fall Meeting*. Contact Executive Secretary William Mankin, 4059 Land O'Lakes Dr., Atlanta 30342.

## OCTOBER

6-9 — *Sea Island: Georgia Orthopaedic Society*. Category 1 credit. Contact David Apple, Jr., M.D., 1938 Peachtree Rd., Ste. 710, Atlanta 30309. PH: 404/352-2234.

11-16 — *Atlanta: American Society of Internal Medicine Annual Meeting*. Category 1 credit. ASIM, 1101 Vermont Ave., Ste. 500, Washington, D.C. 20005. PH: 202/289-1700.



## Re: AIDS Omnibus Bill

Dear Editor:

At a hearing before the State Human Resources Committee on Thursday, February 18, Dr. Jack Menendez, President of MAG, stated that the Georgia Psychiatric Association was "comfortable with the AIDS bill." Apparently some of our GPA staff and committee members have given this impression.

I participated in the brief discussion about this bill at our winter business meeting less than two weeks earlier. The discussion didn't suggest "comfort" to me. I don't see how our state organization could be *comfortable* with a bill that is at such variance with the National APA's guidelines on AIDS confidentiality and management of HIV infected inpatients. (See *Psychiatric News*, January 3, 1988). This bill in essence authorizes "assault-&-battery" of patients: "the individual may be required to submit to an HIV blood test without consent . . . of patient, representative or next of kin . . . using whatever degree of physical force is reasonably necessary" and without due process. This is reminiscent of ECT and frontal labotomies without the patient's consent; but even those required consent of next of kin.

The AIDS epidemic is stressing our basic ethical values. We need to think carefully and proceed cautiously with "what we feel comfortable with."

Sincerely,  
Edward O. Nix, M.D.  
Psychiatrist, Atlanta

## Re: Adolescent Urine Drug Screening

Dear Editor:

The AAP, representing 500 pediatricians in the state of Georgia, opposes the principle of involuntary drug testing of adolescents as described by a Cobb county psychiatrist. [Adolescent Urine Drug Screening, Dec 1987;76:833-837.] Enclosed is a statement from the National American Academy of Pediatrics. [Contact the AAP for Resolution #255(87) — 1987 Annual Chapter Forum, Appendix D-1.] We in the Georgia Chapter feel the alleged absence of doctor-patient relationship in the lab set-up described is unethical.

Drug screening is sanctioned in the context of certain treatment programs, some life-threatening emergency, and work-place situations. Most circumstances in which a parent requests involuntary drug testing of a child are better redirected to involving the child's trust and initiative with more direct primary care relationship.

The Adolescent Committee of Georgia AAP is available as a forum for discussion of this controversy, and AAP urges MAG to oppose any statewide legislation for involuntary drug testing of adolescents.

Sincerely,  
Bethanne Jenks, M.D., MPH  
Chair, Adolescent Committee  
American Academy of Pediatrics

## Re: Abortion Ad

Dear Editor:

Thank you for your fair and thoughtful response to Dr. Keith E. Hannay's criticism about our advertisement for our abortion program that appeared in the *MAG Journal*.

It is distressing that some physicians would seek to impose their own moral, religious, and ethical feelings on their patients, as well as all women.

We appreciate your support in this matter. Thank you.

Sincerely,  
Ann Rose  
Director of Community Education  
Midtown Hospital, Atlanta



## Legislators Look at Health Care

A number of health care-related measures passed during this year's General Assembly in Georgia. Issues of greatest concern to hospitals were these:

- **INFORMED CONSENT.**

Physicians are responsible for informing patients of the risks of surgery for which general or regional anesthesia is used and of diagnostic tests involving contrast materials. Lack of informed consent by itself cannot support a medical malpractice action, and, when a malpractice action is filed, the complaint must include an expert affidavit.

- **CERTIFICATE OF NEED.**

Legislation modifying CON law did not pass; however, the Georgia Hospital Association expects to see CON on the 1989 legislative agenda.

- **DATA COLLECTION.** The Department of Human Resources can develop a state data collection service using hospitals' UB 82 reports.

- **AIDS.** Hospitals have greater responsibility to keep AIDS information confidential. They must give patients 10 days to object to subpoenas for medical records. GHA has recommended that hospitals keep AIDS information separate in the medical record so it can be easily removed in case the record is subpoenaed.

- **OPEN MEETINGS AND OPEN RECORDS.** Though new laws on open meetings do include hospital authorities, the open records legislation excluded documents on planning, marketing, CON preparation, physician recruitment,

and development of quality assurance, peer review, and security systems.

- **MEDICAID.** The legislators approved a \$40,000,000 to \$50,000,000 Medicaid program for children and pregnant women. The governor approved a 4% Medicaid increase.

GHA expects next year's session to include Medicaid reimbursement, CON, insurance pools, a tax on hospital revenues to fund indigent care, and the tax-exempt status of nonprofit organizations.

## TPA's \$2,200 Cost Must Come From \$4,000 DRG Payment

Don't look for any Medicare coverage of tissueplasminogen activator (TPA). The Health Care Financing Administration has announced that the cost of the drug — \$2,200 a dose — will have to come out of hospitals' DRG payments. The average payment for treating heart attack patients is now \$4,000.

Says HCFA Administrator William L. Roper, M.D., "Despite the drug's high price, it is not clear at this point that it will prove ultimately to be a cost-increasing technology for a given hospital admission."

## Both Public and Private Funds Needed to Finance the Cost of AIDS

The American Hospital Association's latest policy on AIDS states that both public and private funds should be made available to victims of the disease.

Shared financial responsibility by

several providers will help ease the burden that could fall on any one hospital, says the AHA. It cites the closing of the nation's first all-AIDS hospital in Houston as an example of how the cost of AIDS can debilitate an institution.

AHA also notes that it may become necessary to prohibit AIDS exclusions in group health policies and to expand Medicaid eligibility.

## Government Plans to Study Effectiveness of Treatment

Effectiveness of treatment has now come under the watchful eye of the Health Care Financing Administration. Next year HCFA will put \$15 million of research into the cost effectiveness versus the cost benefit of various treatments for the same medical condition. Says HCFA, the study will determine whether a treatment is "worth it to society [and] worth it to human life" and whether it "yields a greater effect" than other forms of treatment. The study will look at 10 procedures, including stroke management and coronary artery bypass grafts.

## Adjustments Needed to Give True Financial Picture of Hospitals

Don't be misled by reports that hospitals still have a ways to go in cutting their Medicare expenses, warns the American Hospital Association. Data that show hospitals' expenses — and profits — on the upswing don't give a true financial picture.

Jack Owens, AHA's executive vice-president, points out that the following changes in payment



calculations will show hospitals' actual costs as well as their profits and losses:

- Use a single Medicare base rate for all hospitals, and adjust it to reflect types of patients treated, indirect medical education costs, and local differences in resource prices;
- Put into place an adjustment for severity of illness;
- Adjust Medicare reimbursement to reflect local labor prices;
- Limit losses for small hospitals, because Medicare reimbursement averages do not apply to them;
- Extend the designation of rural referral hospitals for five years or until the elimination of urban and rural distinction;
- Permit all hospitals to provide skilled nursing care; and
- Maintain the periodic interim payment system.

### Hospitals Must Now Have Organ Donation Protocols

The Health Care Financing Administration is now looking at the methods hospitals are using to identify potential organ donors. The government is also checking to see if hospitals are informing those patients' families of their option to permit organ donation.

HCFA requires hospitals to have protocols to encourage donations because of what Administrator William L. Roper, M.D., terms a "critical shortage" of organs and tissues suitable for transplant. That shortage has also led to an HCFA recommendation that written protocols be made part of certification by the Joint

Commission on Accreditation of Healthcare Organizations.

Under current law, hospitals must also have an approved organ procurement agency of potential donors. In addition, they must be members of the United Network for Organ Sharing in Richmond, VA, or lose their Medicare payments.

### Supreme Court Considers State Activities in PRO Proceedings

The U.S. Supreme Court has heard arguments on a case in which a physician claimed his competitors motivated peer review proceedings against him.

In *Patrick v. Burget*, plaintiff Timothy Patrick, M.D., earlier won a \$2 million verdict. The appellate court, however, reversed that decision on the grounds that peer review proceedings are state actions and therefore immune from federal antitrust scrutiny. The Supreme Court is expected to uphold the appellate decision if it finds that Oregon (where the action occurred) adequately supervised the peer review system.

The final decision likely won't be final till early summer.

### HMOs: Growing or Going?

Health maintenance organizations saw little growth during the last months of 1987, likely because of increased competition from other types of insurance and pressure to improve financial performance.

A new survey by InterStudy of Excelsior, MN, shows that growth stood at less than 1% during the final quarter of last year, with no

increase at all in the number of plans for that period.

By contrast, the first quarter of 1987 saw a 10.9% growth rate. That rate dwindled quickly, however, with the total growth for the first three quarters standing at only 12%.

Despite the figures, the Group Health Association of America in Washington, DC, predicts continued growth in HMO enrollment as a result of insurance rate hikes, which averaged 8% last year.

### Hospital Costs on the Rise

The cost of medical care rose 0.8% during the first month of this year, an increase the U.S. Labor Department says is the largest for any month in the last two years. Increases for the last three months of 1987 held at 0.4%.

Overall, consumer prices rose 0.3% during January.

The highest portions of the increase came from outpatient services and hospital room rates, both of which went up 1.2%. In December, they went up only 0.6% and 0.3% respectively.



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\*CARDIZEM® (diltiazem HCl) is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

†See Warnings and Precautions.

Please see brief summary of prescribing information on the next page.

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### BRIEF SUMMARY

Professional Use Information

#### CARDIZEM<sup>®</sup>

(diltiazem HCl)

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#### CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, (3) patients with hypotension (less than 90 mm Hg systolic), and (4) patients who have demonstrated hypersensitivity to the drug.

#### WARNINGS

- Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
- Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
- Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
- Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, LDH, SGOT, SGPT, and other phenomena consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

#### PRECAUTIONS

**General.** CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

**Dermatological events (see ADVERSE REACTIONS section)** may be transient and may disappear despite continued use of CARDIZEM. However, skin eruptions progressing to erythema multiforme and/or exfoliative dermatitis have also been infrequently reported. Should a dermatologic reaction persist, the drug should be discontinued.

**Drug Interaction.** Due to the potential for additive effects, caution and careful titration are warranted in patients receiving CARDIZEM concomitantly with any agents known to affect cardiac contractility and/or conduction. (See WARNINGS.)

Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

As with all drugs, care should be exercised when treating patients with multiple medications. CARDIZEM undergoes bio-

transformation by cytochrome P-450 mixed function oxidase. Coadministration of CARDIZEM with other agents which follow the same route of biotransformation may result in the competitive inhibition of metabolism. Doses of similarly metabolized drugs, particularly those of low therapeutic ratio or in patients with renal and/or hepatic impairment, may require adjustment when starting or stopping concomitantly administered CARDIZEM to maintain optimum therapeutic blood levels.

**Beta-blockers:** Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities.

Administration of CARDIZEM (diltiazem hydrochloride) concomitantly with propranolol in five normal volunteers resulted in increased propranolol levels in all subjects and bioavailability of propranolol was increased approximately 50%. If combination therapy is initiated or withdrawn in conjunction with propranolol, an adjustment in the propranolol dose may be warranted. (See WARNINGS.)

**Cimetidine:** A study in six healthy volunteers has shown a significant increase in peak diltiazem plasma levels (58%) and area-under-the-curve (53%) after a one-week course of cimetidine at 1,200 mg per day and diltiazem 60 mg per day. Ranitidine produced smaller, nonsignificant increases. The effect may be mediated by cimetidine's known inhibition of hepatic cytochrome P-450, the enzyme system probably responsible for the first-pass metabolism of diltiazem. Patients currently receiving diltiazem therapy should be carefully monitored for a change in pharmacological effect when initiating and discontinuing therapy with cimetidine. An adjustment in the diltiazem dose may be warranted.

**Digitalis:** Administration of CARDIZEM with digoxin in 24 healthy male subjects increased plasma digoxin concentrations approximately 20%. Another investigator found no increase in digoxin levels in 12 patients with coronary artery disease. Since there have been conflicting results regarding the effect of digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing CARDIZEM therapy to avoid possible over- or under-digitalization. (See WARNINGS.)

**Carcinogenesis, Mutagenesis, Impairment of Fertility.** A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in *in vitro* bacterial tests. No intrinsic effect on fertility was observed in rats.

**Pregnancy.** Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers.** Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

**Pediatric Use.** Safety and effectiveness in children have not been established.

#### ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater

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than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

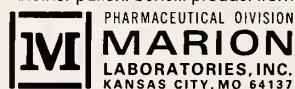
Cardiovascular:	Angina, arrhythmia, AV block (first degree), AV block (second or third degree—see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.
Nervous System:	Amnesia, depression, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.
Gastrointestinal:	Anorexia, constipation, diarrhea, dyspepsia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.
Dermatologic:	Petechiae, pruritus, photosensitivity, urticaria.
Other:	Amblyopia, CPK elevation, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established. Issued 6/87

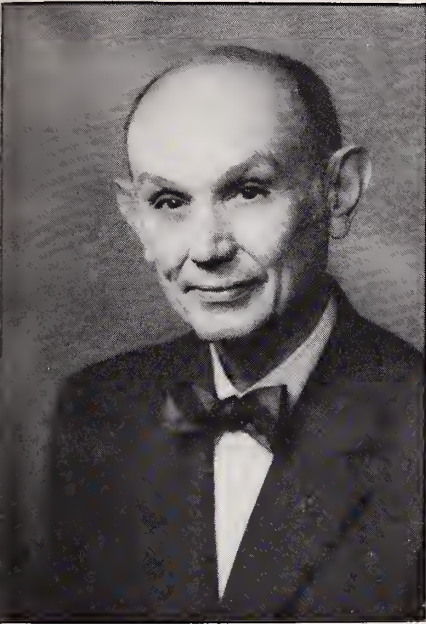
See complete Professional Use Information before prescribing.

**References:** 1. Schraeder JS: *Mod Med* 1982;50(Sept): 94-116. 2. Cahn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): *Heart Disease: A Textbook of Cardiovascular Medicine*, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39. 3. O'Rourke RA: *Am J Cardiol* 1985;56:34H-40H. 4. McCall D, Walsh RA, Frahm ED, et al: *Curr Probl Cardiol* 1985;10(8):6-80. 5. Frishman WH, Chorlap S, Goldberger J, et al: *Am J Cardiol* 1985;56:41H-46H. 6. Shopiro W: *Consultant* 1984;24(Dec):150-159. 7. O'Hara MJ, Khurmi NS, Bowles MJ, et al: *Am J Cardiol* 1984;54:477-481. 8. Strauss WE, McIntyre KM, Pans AF, et al: *Am J Cardiol* 1982;49:560-566. 9. Feldman RL, Pepine CJ, Whittle J, et al: *Am J Cardiol* 1982;49:554-559.

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Joseph P. Bailey, Jr.

**T**he Practice of Medicine, The Medical Profession, Patients, Patient Care, Professionalism, Education, Research, Medical Ethics.

These are all words that have specific meaning to each of us, and yet, their meaning to those outside of medicine may be different. The physician is a special person in our society who functions to serve, to be the servant of the patient. His or her care is provided with intelligence, hard work, and compassion. That care is also provided with an all encompassing concern for the patient which extends far beyond the single issue of a particular problem or illness. This care is born of a tradition based on performance, fact, and sacrifice — not on one of veiled hope. As has been emphasized this past year by stressing a healthy lifestyle, it is important for the public to know that our concerns extend beyond the issue of sickness.

We must not lose sight of what we have accomplished. Examine what has happened to such problems as: infections such as smallpox, poliomyelitis, tuberculosis, and syphilis; surgical intervention, with major advances being noted in the arena of cardiovascular disease, transplantation, plastic repair, joint replacement, arthroscopic surgery, and cataract surgery; the management of gout; the treatment of hypertension; and pediatric care, to name just a few. Also, diagnostic techniques have been a major contribution to our advances as noted by magnetic resonance imaging, computerized axial tomography, nuclear medicine, endoscopy, dye contrast studies, and general pathology.

These are all very positive considerations but, obviously, they are associated with other definitive and yet unresolved problems such as: cancer, diabetes mellitus, vascular diseases, developmental abnormalities, viral infections, musculoskeletal disease, and immunologic disorders.

We have made great progress, and there is much yet to come. Let us join together to bring our profession to even greater levels of satisfaction for us and our patients. To do this, we need to come

together bound by continued belief in ourselves and our professional abilities. *You need your help!* This is to indicate that physicians must join in the mutual pursuit of the betterment of the profession and its provision of care. We must, in trying circumstances, resort to belief in the fundamental and altruistic character of the physician to function for the betterment of the patient. This girds us with armor of uncommon protective ability and yet, it also makes us vulnerable to any chinks in this armor which for certain will be found by our detractors. But to be human is to be vulnerable. We will make errors in judgement. However, to recognize and have compassion for *all*, including ourselves, is mandatory, striving to effect positive change for everyone.

To accomplish this we must bind ourselves together through the MAG at the state level and the AMA at the national level to have an effective voice and ability to govern the fate of medicine. Although a great task, I intend in my small way to work to this end. I implore you to join in the effort and will unhesitatingly remind you of this need at every opportunity. The success of the Medical Association of Georgia and its Auxiliary this year will not be mine, but ours. ■

*Joseph P. Bailey, Jr.*



## NEW MEMBERS

Aicher, John A., Family Practice — Lumpkin — 102 Self Dr., Dahlonega 30533

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## PERSONALS

*Dougherty CMS*

**A**lbany surgeon **Van Cise Knowles, M.D.**, was honored recently at the Albany Sertoma Club as Sertoman of the Year, the highest honor the club can grant a member. Dr. Knowles was selected because of his leadership ability, his involvement in community activities, and his extensive work in the club.

*Hall CMS*

**W**• **David Weiss, M.D.**, an orthopedic surgeon, has joined the staff of Saint Joseph's Hospital-Dahlonega.

A native of Atlanta, Dr. Weiss completed his pre-med education at Tulane University School of Medicine. He interned at Baylor University Affiliated Hospitals in Texas and completed his residency program in orthopedic surgery at Georgia Baptist Hospital and Scottish Rite Hospital. He also completed a fellowship in clinical spine study with Dr. Phillip Benton in Atlanta and a sports medicine fellowship at Hughston Hospital in Columbus, Georgia.

*Medical Association of Atlanta*

**E****va Arkin, M.D.**, recently became a Fellow of the American College of Obstetrics and Gynecology.

She practices in the Northside area and has a satellite office in Norcross.

*Peachbelt CMS*

**E****ric Zanghi, M.D.**, an internal medicine specialist, has

opened his practice in Warner Robins.

Zanghi, 32, recently was discharged from the U.S. Navy where he was stationed at the U.S. Naval Hospital in Yokosuka, Japan. He served there as staff doctor in internal medicine.

*Stephen-Rabun CMS*

**J****udith Ahrano, M.D.**, a pediatrician at Toccoa Clinic, has been accepted as a Fellow of the American Academy of Pediatrics.

**Raj Bhole, M.D.**, was elected as a Fellow of the Royal College of Surgeons Canada, in orthopedic surgery. Dr. Bhole is a diplomat of the American Board of Orthopedic Surgery and an assistant clinical professor at Emory University School of Medicine. His office is located in Toccoa and he is on the staff at Hart County Hospital.

## OBITUARIES

*Berry Bowman*

Albany orthopedic surgeon, Berry Bowman, M.D., age 78, died last March.

A native of Hot Springs, Ark., Dr. Bowman obtained his medical degree at Tulane University. He served in the Army Air Corps at Turner Field in Albany as chief of general surgery and orthopedics. He was active in local medical organizations, serving as chief of staff and chief of orthopedics at Phoebe Putney Hospital and on the hospital's credential committee for many years.

Dr. Bowman was president of Southwest Georgia Historical Society for 5 years and president of the Albany Civil War Roundtable. A founder and charter board member of Deerfield Private School, Dr. Bowman also served as chairman of the board of trustees of Southwest Georgia Private Schools. He was a member of the Georgia Historical Society, authored several medical papers, and reviewed Civil War books for the Albany library for several years. Dr. Bowman retired from his office practice in 1979.

Survivors include his wife, three sons, and six grandchildren.

*T. Sterling Claiborne, Sr.*

T. Sterling Claiborne, Sr., M.D., age 79, of Atlanta, a retired cardiologist, died recently of complications of Alzheimer's disease. Dr. Claiborne had practiced internal medicine at St. Joseph's and Piedmont hospitals in Atlanta from 1937 to 1981. He helped found the Georgia Heart Association, now the Georgia Division of the American Heart Association, in 1949 and a year later served as its second president. He also helped launch a heart clinic system in the state for patients unable to pay for adequate care. Dr. Claiborne also served as a clinical professor of medicine at Emory University School of Medicine from 1953 until 1975.

Born in Louisiana, Dr. Claiborne graduated from the University of Virginia and received his medical degree there with honors in 1932. He spent his internship and residency at Boston's



Massachusetts General Hospital and Lahey Clinic.

During World War II, he was the cardiologist of the "Emory unit" of the Army's 43rd General Hospital and served in North Africa and France.

He was a former chairman of the board of trustees of the Fulton County Medical Society; a former governor for Georgia of the American College of Physicians; a former president of the Southeastern Clinical Club; a former member of the state Board of Health.

Surviving are his wife, a son, two daughters and seven grandchildren.

## *A. O. Goldsmith*

A. O. Goldsmith, M.D., died last March at the age of 67.

A native and lifelong resident of Albany, Dr. Goldsmith attended Emory University in Atlanta and was a 1950 graduate of the Medical College of Georgia. He completed his internship and residency at Charity Hospital of Louisiana at New Orleans. He had practiced obstetrics and gynecology in Albany since 1954 and was former chief of obstetrics at Phoebe Putney Memorial Hospital. A captain in the Air Force during World War II, he was a member of Temple B'Nai Israel, served as a member of the board of trustees and was president from 1966 until 1969.

Dr. Goldsmith was a former vice president of Dougherty County Medical Society and was a Fellow of the American College of Obstetrics and Gynecology.

Survivors include his wife, two sons, a brother, and a sister.

## *W. Roy Mason, Jr.*

W. Roy Mason, Jr., M.D., of Atlanta, a retired director of student health at Emory University, died of cancer recently. He was 74.

Born in Virginia, Dr. Mason taught anatomy at the University of Virginia Medical School from 1936 until becoming director of student health at Emory in 1950. He retired in 1983 and worked for the Social Security Disability Bureau.

Surviving are his wife, two sons, a daughter, a brother, seven grandchildren, and a great grandchild.

## *Robert Lee Oliver, M.D.*

A prominent Savannah physician, Robert Lee Oliver, M.D., died last January after a short illness.

Dr. Oliver graduated from Vanderbilt University, magna cum laude, and received his medical degree from Johns Hopkins University. He was a member of Southeast Surgical Congress and served as president of the MAG from 1957-1958.

Dr. Oliver served on the staffs of the Central of Georgia Railway Hospital, St. Joseph's Hospital, Candler General Hospital, Georgia Infirmary, and Memorial Medical Center. He served as medical director for Savannah Foods and Industries for 40 years, from 1935 to 1976.

Surviving are his wife, a daughter, two sons, and five grandchildren.

## *George Dillingham Schuessler*

George Dillingham Schuessler, M.D., a founder of Blue Cross and Blue Shield of Georgia and a

physician who practiced medicine in Columbus for over 30 years, died last February. He was 80 years old.

Dr. Schuessler was born in Columbus. He earned a bachelor's degree at University of the South of Sewanee, Tenn., and held a doctorate at Vanderbilt University, Nashville, Tenn. From 1940 to 1945 he served in the U.S. Army, retiring from the Army Reserves in 1968 as a lieutenant colonel.

Dr. Schuessler was an original incorporator of Physicians Service, Inc., now Blue Cross and Blue Shield of Georgia, serving as a board member, officer and medical director between 1950 and 1974.

He served on the staffs at The Medical Center, Doctors Hospital, and St. Francis Hospital before retiring from medical practice in 1983. He was a member of the Country Club of Columbus, the Columbus Museum of Arts and Crafts, the Retired Officers Association, Historic Columbus Foundation, and was a former member of the Muscogee Lions Club. He belonged to St. Luke United Methodist Church.

Survivors include his wife, a daughter, two sons, and three grandchildren.

## *Robert A. Sears*

Robert A. Sears, M.D., of Macon, a retired chief of neurosurgery at Emory University Hospital, died of cancer last January.

Born in Michigan, Dr. Sears was a 1939 graduate of Harvard University. He later received his medical degree from Yale University School of Medicine in 1943 and was certified by the



American Board of Neurosurgery in 1955. He served as a lieutenant colonel in the U.S. Navy Medical Corps during World War II.

Dr. Sears was chief of neurosurgery at Emory University Hospital from 1966 until 1970 and taught at Emory University School of Medicine from 1963 to 1973.

He had been the neurosurgeon research fellow at Boston Children's Hospital in 1947 and 1948, a staff physician at Montreal Neurological Institute from 1948 until 1950, chief resident of neurosurgery at both Boston Children's Hospital and Peter Bent Brigham Hospital from 1950 until 1953. From 1953 until 1963, he was in private practice in Atlanta. Dr. Sears was one of the first neurosurgeons at the Neurological Institute of Central Georgia, founded in 1973. He retired in 1983.

He was a member of the Georgia Neurosurgery Society, the Harvard Cushing Society of the Congress of Neurosurgeons, Southern Neurosurgery Society, and the American College of Surgeons.

Surviving are his wife, two sons, a daughter, two brothers, and five grandchildren.



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# Regionalization of Trauma Care: Its Effect on Quality of Care and Community Economic Resources

Virginia C. G. Mork, M.D., F.A.C.E.P.

## Introduction

**T**RAUMA, the number one cause of death for persons between the ages of 1 and 44, is also the number one cause of years of potential life lost (YPLL) in this country. Regionalization of trauma care, including the designation of trauma centers, has a significant impact on reducing mortality and morbidity of seriously traumatized patients and reducing this drain on our human resources. Decisions on implementation of health care systems such as trauma systems must include a clear understanding of the impact on quality of care as well as of the factors which may affect the community economic resources. The value of trauma care systems in improving outcome statistics for the multisystem trauma patient is well documented. The data concerning the economic factors are not as well defined for all communities, but several studies have provided valuable clues. A summary of both issues is appropriate in order to assist local medical community efforts to improve the care of trauma patients. Medical and fiscal respon-

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**A number of studies have been conducted demonstrating the ability of organized trauma systems and trauma centers to reduce morbidity and mortality due to trauma.**

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sibility may both be served in this effort.

## Historical Perspective

After the Korean and Vietnam War experiences, ex-military physicians sought to duplicate the efficient care which had proved so successful in salvaging the injured. Well-trained paramedical personnel in the field, effective communication, rapid transportation (helicopters), and well-equipped physicians ready to

deliver immediate definitive care became the standard in the management of the traumatized patient. After their return to civilian medical practice, they demanded the same chance to salvage the severely traumatized.

The modern era of emergency services and the beginning of the civilian system's approach to improve trauma care began in 1966, when the National Academy of Science/National Research Council Committees on Shock and Trauma published the white paper, *Accidental Death and Disability: The Neglected Disease of Modern Society*. This document<sup>1</sup> outlined the building blocks for an improved trauma care program, much of which has been incorporated into the programs which now exist. The first civilian trauma unit was established at Cook County Hospital in Chicago in 1966.<sup>2</sup> In that same year, the Maryland Shock-Trauma Unit expanded its research in shock into that of the severely traumatized.<sup>3</sup> The regionalization of trauma care was initially developed by Boyd in Illinois. Illinois and Maryland, with help from their state governments,

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led the way in categorization of the existing facilities as well as regionalization of specialty facilities (i.e., burn centers and spinal cord injury centers).

With the apparent success of these pioneer centers, Congress was spurred to enact the Emergency Medical Services Systems (EMSS) Acts of 1973, the purpose of which was to:

*Amend the public health service act to provide assistance and encouragement for the development of comprehensive area-wide Emergency Medical Services Systems.<sup>4</sup>*

Among other things, this act provided states with grants to aid them in establishing programs to coordinate their emergency medical services. Once the local and regional EMS organizations began to develop functioning systems, it became apparent that hospitals were not providing a standard level of care for every category of patient. Hence, the old policy that the patients should be transported to the nearest hospital raised some ethical question for the EMS personnel. The policy evolved that each patient should be taken to the nearest *appropriate* facility. The difficulty that arose with this distinction was in deciding which hospitals were appropriate. In the case of the trauma patient, the American College of Surgeons Committee on Trauma stepped in with a set of guidelines<sup>5</sup> for categorization of facilities and provided a mechanism for the review of applying hospitals and their designation. These standards are updated regularly.<sup>6</sup>

The systems approach to trauma includes vertical categorization of hospital resources and the selection of a limited but appropriate number and level of trauma centers (Table 1).<sup>7</sup> It is this systems approach which provides an improved quality of care as well as more efficiently utilizing community resources.

### Quality of Care

A number of studies have been conducted demonstrating the ability of organized trauma systems and trauma centers to reduce morbidity and mortality due to trauma. In 1979, West, et al<sup>8</sup> compared the survival of motor vehicle accident victims in two counties. San Francisco County with its system of organized trauma care had one central trauma center. In Orange County, trauma patients were taken to the nearest receiving hospital. Approximately  $\frac{2}{3}$  of the non-central nervous system-related deaths and  $\frac{1}{3}$  of the central nervous system-related deaths in Orange County were judged to have been preventable. Only one death in San Francisco County was judged to be preventable. They concluded that an organized trauma system with access to a trauma center can improve survival rates for victims of trauma.

In 1983, West, et al<sup>9</sup> reported on the status of trauma patients in Orange County after the implementation of a trauma system in 1980. Their results indicated a significant reduction in the number of deaths judged to be preventable as well as an increased percentage in the patients who received appropriate surgical intervention. Cales in 1984<sup>10</sup>

also reported on the effect of implementation of a regional trauma system in Orange County. He found that prior to implementation, the percentage of potentially salvageable deaths was 34%. After implementation of a regional trauma system, this dropped to 15%. Most of the deaths due to trauma (7%) which occurred after implementation occurred when patients were taken to a non-trauma center. Hence, he concluded that the implementation of a regional trauma system engenders significant improvements in trauma care and a reduction in the death rate from vehicular trauma.

In 1986, Shackford et al<sup>11</sup> reported on the impact of regionalization on trauma mortality in San Diego County. The care of major trauma victims was considered suboptimal in 32% of patients before regionalization, compared to 4.2% after regionalization. Preventable deaths occurred in 13.6% of fatalities occurring before implementation of a trauma system, compared to 2.7% after implementation. They report that regionalization of trauma significantly reduced delays, inadequate care, and preventable deaths due to trauma.

These and other studies demonstrate that the implementation of a regional organized system of trauma care results in a significantly higher quality of care, as measured in lives saved.

### Economic Issues

The health care industry is in economic evolution. With the past emphasis on retrospective reimbursement and high technology care, recent forces have refocused the attention of health care managers. Prospective payment systems developed both in the private and public sector have shifted the economics of medical care into the marketplace. Hospitals have had to deal with certificates of need (CON), Diagnosis Related Groups (DRGs), and other shotgun approaches to the containment of skyrocketing health care costs. The approach of regionalization of trauma care,

**TABLE 1 — American College of Surgeons Nomenclature and Capabilities of Trauma Centers**

<b>LEVEL I (Regional Trauma Center):</b> Resuscitation, initial care, standard operative, intensive care management, and specialized care. Education and investigation for all trauma professionals and problems within the region, within its capabilities.
<b>LEVEL II (Areawide trauma service center):</b> Resuscitation, initial care, and standard operative, intensive care management, within its capabilities.
<b>LEVEL III (Local trauma center):</b> Resuscitation and initial care within its capabilities.



which has recently become prevalent, combines the goals of quality care as well as increasing community economic efficiency in dealing with this "Number One" cause of premature death.

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**Comparing reimbursement of trauma patients to reimbursement of all inpatients revealed that trauma patients were reimbursed less than all patients combined (77% verses 93%, respectively).**

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What is the economic impact of trauma system implementation on the individual designated hospitals as well as on the community? Cooper, et al<sup>12</sup> conducted a financial analysis of an inner city trauma center in Louisville, Kentucky. The premise of the study was that with changes in the economy and in tax rules that the trauma service might be a financial drain on the hospital even though the emergency department might be a cost-effective portal of entry for patients. Especially in an inner city with a larger proportion of medically indigent, a trauma service might not be cost-effective for an individual institution. For the trauma service in this institution, total collections were 77% of charges. There was no difference in collections for patients who had blunt versus penetrating injury, violent versus nonviolent injury, or in the method of initial referral to the trauma center (direct prehospital entry or referral from another institution). This study was done under the retrospective reimbursement system.

Another study which was conducted under the retrospective

reimbursement system was by Oakes, et al<sup>13</sup> in 1985 when they examined the financial impact of the management of motor vehicle accident (MVA) victims on their institution. Between July 1, 1982, and June 30, 1983, a total of 290 patients were discharged from the Santa Clara Valley Medical Center after treatment for injuries sustained in motor vehicle accidents. These patients represented 2.1% of all discharges but 6.6% of all patient-days and 6.4% of total hospital charges. Ninety-three percent of the MVA patients had some form of third party coverage (Medicare, Medi-Cal, or some other form of insurance). Seven percent of these patients did not have any medical sponsorship. Hospital charges were related to patient days directly. Overall reimbursement for MVA patients was 80.3% of charges. The authors felt that caring for MVA patients was a breakeven proposition for this institution and that the burden of nonreimbursement was due to the uninsured motorists.

Jacobs in 1985,<sup>14</sup> examined the effect of prospective reimbursement on trauma patients. Using prospective methodology, 1,018 patients from the hospital trauma registry were studied. Trauma Score and Injury Severity Scores were used as objective measures to test the hypothesis that hospitals are reimbursed less than their costs to manage severely injured patients. The data revealed that the more severely injured patients (based on Trauma Score and Injury Severity Score) consumed more resources than were reimbursed in the Diagnosis-Related Group (DRG) system. Jacobs predicted that if prospective payment systems became more prevalent, hospitals might find other kinds of patients which might be more cost-effective. Hence, if inadequate payment became a disincentive to managing trauma patients, hospitals might choose not to do so.

In 1986, Jacobs and Schwartz<sup>15</sup> reported on the extent of the finan-

cial impact of prospective payment on trauma centers. They studied 1,526 trauma registry patients by demographic, physiologic, anatomic, investigational, and clinical data. They found that severely injured patients consumed more resources, had longer hospital stays, and were prospectively reimbursed less than the cost of their hospitalization. Comparing reimbursement of trauma patients to reimbursement of all inpatients revealed that trauma patients were reimbursed less than all patients combined (77% versus 93%, respectively). When updated reimbursement weighting codes were utilized, the loss to the hospital increased, with the hospital being reimbursed 56% of the total bill for trauma patients. The authors recommend that there be an alternative reimbursement system for trauma patients, based on voluntary national norms, objective national outcome criteria, and appropriate trauma management.

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**The economic evaluation of trauma systems cannot be complete without considering the gain by society when a preventable death is actually prevented. The fact is, however, that this gain by society is very difficult to quantify.**

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In an effort to provide more cost-effective care to very critically injured patients, Fischer, et al<sup>16</sup> reviewed the direct costs of care for 77 consecutive patients with Trauma Score of four or less, a group with a very low probability of survival. Seventy-four of these pa-



tients died, with only four of the nonsurvivors living more than 24 hours. Only one of the three survivors achieved a productive recovery. The total direct costs for all of these patients was \$544,477.66. Based on the analysis of the data, the authors propose cost-effective clinical guidelines on who to resuscitate in this category of patients:

1. They state that it is futile to continue resuscitation efforts if a valid Trauma Score of 1 or 2 is confirmed shortly after the initiation of appropriate resuscitative measures.
2. If a patient with an admission trauma score of 4 or less does not achieve cardiovascular stability in response to appropriate resuscitative measures within 1 hour of admission, continued therapy is futile.

The authors feel that these guidelines provide an objective means of limiting the allocation of resources on patients who have no change of survival.

Tennant in 1983<sup>17</sup> discussed the financial impact of improved trauma care on communities, summarizing a presentation by D. D. Trunkey, then Chief of Surgery at San Francisco General Hospital. He estimates that the total direct and indirect costs of trauma are \$87.4 billion annually. Since trauma is the number one cause of death from age 1 to 44, a death due to trauma is in most cases the loss of a person in the prime of his/her productive years. The economic evaluation of trauma systems cannot be complete without considering the gain by society when a preventable death is actually prevented. The fact is,

however, that this gain by society is very difficult to quantify. Another gain by the community lies in the more efficient use of resources when only certain hospitals treat certain classes of patients. Duplication of services within the community has been and will continue to be a drain on the resources of that community and one of the main reasons for the skyrocketing cost of medical care. If, however, only certain hospitals are allowed to gear up for the care of these patients, costly duplication may be avoided.

### Summary

It has been clearly shown that regionalization of trauma care has a significant impact on reducing the mortality and morbidity of seriously injured trauma patients. The quality of care which can be offered to these patients at trauma centers has changed patterns of survival which have been longstanding in the face of technology which has not changed significantly in the intervals studied. It is also clear that the institutions which decide to offer these services cannot expect to gain significant financial advantage, either under retrospective or prospective reimbursement systems. It is clear that for some hospitals to remain in the "Trauma Center Business," alternative reimbursement strategies may need to be offered. However, there will always be some institutions that will continue to offer these services, either as a public service or as a loss leader. It is these committed institutions which will allow the community to reap the full economic benefit of trauma system development — when fully productive individuals are returned to the community rather than buried.

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# Subclavian to Carotid Artery Bypass for Occlusion of the Common Carotid Artery

## *A Report of Two Cases and Review*

Mark J. Costantino, M.D., Thomas A. Montgomery, M.D.

### Abstract

**THIS PAPER DESCRIBES TWO PATIENTS who underwent subclavian to internal or external carotid artery bypass for total or near total occlusion of the common carotid artery. The clinical presentations, indications for surgery, and surgical techniques are discussed in detail. Special emphasis is placed on the diagnosis, including the use of late phase angiography and noninvasive Doppler Scanning to identify these rather unusual lesions. Gratifying results can be expected with this procedure in selected symptomatic patients with appropriate lesions.**

oped bilateral amaurosis fugax. Non-invasive vascular laboratory studies suggested significant bilateral carotid artery disease. A subsequent arteriogram revealed a 75% stenosis of the right internal carotid artery as well total occlusion of

the left internal carotid artery. The left external carotid artery was patent and filled the left middle cerebral artery via the ophthalmic artery. In addition, there was a tight stenosis of the left proximal common carotid artery.

On 1/25/84, the patient underwent a right carotid endarterectomy without incident. Postoperatively, the patient had no more right eye symptoms but continued to have transient blind spells involving his left eye. On 4/11/84, he underwent a left subclavian to external carotid artery bypass and external carotid endarterectomy. The bypass was carried out using a 6mm Dacron

tients with unusual manifestations of carotid occlusive disease and their treatment.

### Case Reports

CASE 1. The patient was a 71-year-old white man who was first seen in 1983 with asymptomatic carotid bruits and stable claudication. He had a history of hypertension and diabetes but no clinical heart disease at that time. He was seen periodically and eventually devel-

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**O**CCLUSIVE DISEASE of the carotid arteries is a common and well known cause of stroke. Carotid endarterectomy is a time proven treatment for selected patients with this disease. In general, patients with stenotic or ulcerative lesions of the carotid artery and appropriate symptoms, that is, transient ischemic attacks or stable strokes, are considered candidates for this surgery. In appropriate candidates, results can be expected to be excellent. Surgery is usually contraindicated in patients with total occlusion of the common or internal carotid artery. Occasionally, however, a patient with totally occluded common carotid artery will maintain a patent internal or external carotid artery. If these patients are symptomatic, revascularization of these arteries can be rewarding and effectively relieve their symptoms. This paper describes two pa-



graft. He has remained asymptomatic for 2 years.

CASE 2. The patient is a 64-year-old white woman who presented with a history of multiple left hemispheric TIAs. Her history included smoking and hypertension. Physical examination revealed an absent left carotid pulse. An arteriogram revealed a totally occluded left common carotid artery. The left internal carotid artery remained patent and filled via retrograde flow

from the left external carotid artery (Figures 1, 2).

On 11/1/85, the patient underwent a left subclavian artery to left internal carotid bypass with endarterectomy utilizing a 6mm knitted Dacron graft. Postoperatively, the patient has remained completely asymptomatic for 6 months.

#### Discussion

Surgery on the carotid artery bifurcation for occlusive disease ac-

counts for more than 90% of carotid artery surgery. Carotid artery revascularization was first described by Eastcott, Pickering, and Rob in 1954.<sup>1</sup> Since that time, carotid endarterectomy has become the most commonly performed peripheral vascular operation. Operations on the arch vessels for occlusive disease are much less common and account for less than 10% of operations performed. Total occlusion of the common carotid artery



Figure 1. Aortic arch arteriogram of patient #2. Note the total occlusion of the left common carotid artery.



Figure 2. Late phase arteriogram of patient #2. Note the filling of the internal carotid artery via the external carotid artery.



can result from the retrograde thrombosis of the artery following total occlusion at the carotid bifurcation or from antigrade thrombosis following total occlusion of a proximal arch lesion.<sup>2</sup> Occasionally, either the internal or external carotid artery or both arteries may remain patent following total occlusion of the common carotid artery. These patients can remain symptomatic with hemispheric ischemic episodes or symptoms of retinal ischemia. If they are identified, appropriate revascularization can be done, often with gratifying results.

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**Diagnosis of the patient internal or external carotid artery in the presence of the totally occluded common carotid artery depends upon accurate angiography and particularly late injection views.**

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Diagnosis of the patent internal or external carotid artery in the presence of the totally occluded common carotid artery depends upon accurate angiography and particularly late injection views. Since these vessels frequently fill via retrograde flow from collateral vessels of the external carotid system, they are visualized only in the late arterial phase of the arteriogram. Occasionally, the vascular laboratory will suggest that the internal or external carotid artery is still patent in the patient with the obvious occlusion of the common carotid artery. Duplex scanning will visualize the vessels, and the detection of blood flow by Doppler and spectrum analysis confirms the patency of the branch vessels. Some have suggested that Doppler and

spectrum analysis may be more sensitive than angiography in detecting very critical stenoses of the carotid artery and have operated on patients based on this test alone.<sup>3</sup> Obviously, the timing of the angiogram is critical in making this diagnosis and identifying these vessels.

Treatment of common carotid and aortic arch lesions generally fall into three categories: endarterectomy, intrathoracic bypass, and extraanatomic bypass.<sup>4-6</sup> Initial descriptions of the management of these lesions discussed either intrathoracic bypass or endarterectomy as the procedure of choice. However, these procedures are not without morbidity and mortality.<sup>5</sup> Extraanatomic bypass has the advantage of avoiding a thorotomy and has proven satisfactory for many of these unusual lesions.<sup>7,8</sup> The common carotid to subclavian artery bypass is a common method of managing subclavian artery stenosis with or without steal syndrome. Reversing this bypass, that is, a subclavian to carotid bypass, has been an effective method of revascularizing the totally occluded common carotid artery. In both of the patients described, knitted 6mm Dacron grafts were utilized for the bypass. Two incisions were used, a short transverse supraclavicular incision for exposure of the subclavian artery and an oblique incision anterior to the sternocleidomastoid muscle for exposure of the carotid bifurcation. A tunnel was developed posterior to the sternocleidomastoid muscle (Figure 3). Shunts were not used. The postoperative period was similar to a standard carotid endarterectomy.

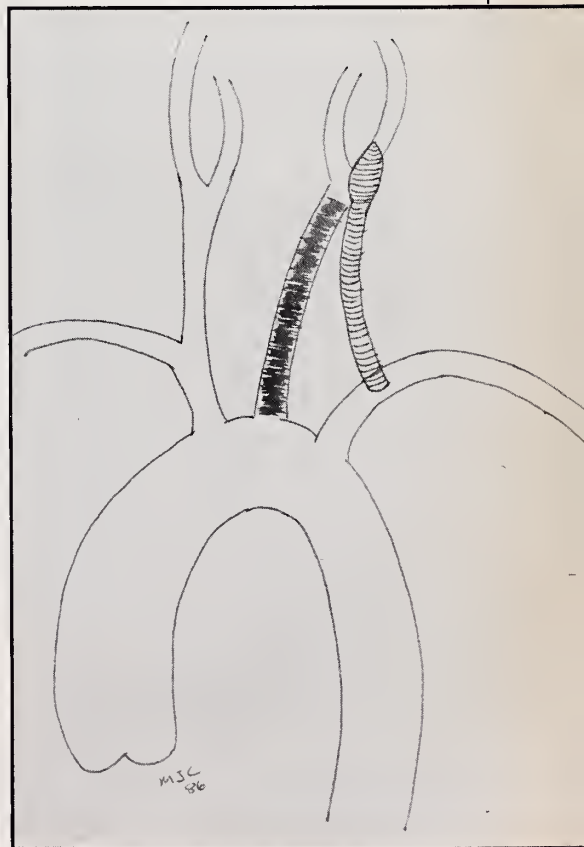
**R**evascularization of the internal carotid artery is well accepted for appropriate patients with symptomatic lesions. The still patent internal carotid artery in the patient with a totally occluded common artery offers a rare opportunity to salvage this vessel prior to its certain total occlusion. The patient with a

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**Reversing this bypass, that is, a subclavian to carotid bypass, has been an effective method of revascularizing the totally occluded common carotid artery.**

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still patent external carotid artery under these circumstances is somewhat more unusual. The external carotid artery is certainly an important source of collateral circulation in the patient with occlusion of the internal carotid artery. The retinal circulation as well as the hemispheric circulation can be supplied by collateral flow from this major branch. There have been many reports describing revascu-



*Figure 3. Diagram of subclavian to internal carotid artery bypass.*



larization of the external carotid artery.<sup>9-11</sup> Results have generally been good though this procedure is not without risk. Bypass to this vessel is unusual but occasionally is indicated.<sup>12</sup> Our first patient had recurrent amaurosis fugax which was relieved completely following external carotid bypass.

### Conclusion

There are patients with totally occluded or nearly occluded common carotid arteries that still maintain patency of one or more of the branch vessels. These patients may remain symptomatic and are at risk for a neurologic event. Diagnosis depends on accurate arteriography, though it may be suggested by the noninvasive vascular laboratory. Revascularization by subclavian to carotid bypass has been effective in relieving these patients of their symptoms. The procedure is relatively simple with acceptable morbidity and mortality.

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# Myths or Facts?

- Even moderate social drinkers may risk liver damage.
- Women are more likely to suffer liver damage from alcohol than men.
- Most victims of liver disease are *not* alcoholics.

All three statements are *true*.

How many did you get right?

Many people are confused about the effects of alcohol on the liver—and *what you don't know can hurt you*.

A pamphlet on *myths* and *facts* tells what you can do to protect yourself and your loved ones. For your free copy, send a stamped self-addressed business envelope to:



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# The Atypical Mycobacteria: Five Year Hospital Experience and Review

David L. Anders, M.D.

## Introduction

**T**HE ATYPICAL MYCOBACTERIA are classically those which remain of the genus *Mycobacterium* after the tuberculosis complex (*M. tuberculosis*, *M. bovis*, *M. africanum*, and *M. microti*) is removed. It may be more practical, however, to include all but *M. tuberculosis* under the classification of atypical. The label "atypical" is somewhat misleading, however, since all of the organisms so listed display properties characteristic of the genus *Mycobacterium*. The atypical group has also been called the "anonymous mycobacteria," "opportunistic mycobacteria" and "mycobacteria other than *M. tuberculosis*." Wolinsky<sup>1</sup> has proposed that the

## Abstract

**O**VER A 5-YEAR PERIOD, 106 patients were discharged from Georgia Baptist Medical Center with the diagnosis of disease due to Mycobacteria. Of those patients with identifiable mycobacterial organisms by culture, 26% grew atypical mycobacteria.

The atypical mycobacteria are ubiquitous organisms that infrequently cause disease in man. When disease does occur, it usually appears clinically to be very similar to the pulmonary disease of *M. tuberculosis*. It is more likely to occur in the elderly, whites, and persons with pre-existent lung disease. The most frequent atypical mycobacterium causing disease in the Southeast United States is *M. avium* complex, with *M. Fortuitum* complex also being a common pathogen.

Current guidelines for therapy are not well established and observation may be indicated. When drug therapy is instituted, more drugs are given for a longer period of time than compared to pulmonary tuberculosis, and antibiotics such as amikacin and cefoxitin may be of use. Surgery is the treatment of choice in appropriate cases of localized *M. avium* disease.

group be called "non-tuberculous mycobacteria." However, tradition and familiarity have maintained the

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popular use of "atypical" to describe these mycobacteria which are associated with histological and clinical events typically caused by *M. tuberculosis*.

In general, the atypical mycobacteria are less contagious, less frequently of clinical significance, and more resistant to traditional anti-tuberculous therapy than is *M. tuberculosis*. In the laboratory, the two groups may be distinguished by the almost unique (some exceptions do exist) ability of *M. tuberculosis* to accu-

mulate niacin.<sup>2</sup> Other differences, similarities, and characteristics will be discussed in this paper by a review of the cases of atypical mycobacteria at Georgia Baptist Medical Center and a review of the medical literature.



## Methods

### Selection of Patients

The International Classification of Diseases (ICD-9-CM)<sup>3</sup> coding system was employed to review the permanent medical records at Georgia Baptist Medical Center (GBMC) which had been classified under the diagnosis of "Tuberculosis (010-018)" and "Diseases due to other mycobacteria (031)" for the 5-year period beginning January 1, 1981, and extending through December 31, 1985. There were 119,971 GBMC discharges during this 5-year period.

Of the 106 patients listed with these diagnoses, 84 records were available for review. Three broad categories of patients were established: (1) those patients with culture-proven *M. tuberculosis*; (2) those patients with culture-proven mycobacteria of the atypical group; and (3) those patients who, because of historical and/or clinical findings, were felt to have mycobacterial disease at the time of discharge from the hospital (at which time diagnoses are coded by the ICD-9-CM system) but were eventually culture-negative for mycobacterial organisms. Medical records for Group 2 were then evaluated for the presence of pre-existent pulmonary disease; immunocompromised states; clinical manifestations of cough, sputum production, fevers, weight loss, hemoptysis; chest roentgenogram changes; secretions cultured; purified protein derivative (PPD) testing; results of acid-fast staining; and cigarette smoking history.

### Results

Of 84 patients reviewed, 29 (34.5%) had culture-proven *M. tuberculosis*, 10 (11.9%) had atypical mycobacteria, 44 (52.4%) had no acid-fast bacilli (AFB) by culture, and one (1.2%) had a few AFB which were not identified. Of those patients with identifiable mycobacterial organisms by culture, 25.6% (10 of 39) grew atypical mycobacterial. For the 5-year period, the in-

cidence of all mycobacteria was at least 32.5 cases per 100,000 discharges (39/119,971) and of atypical mycobacteria at least 8.3 cases per 100,000 discharges (10/119,971). If the 22 patients whose records were unavailable are assumed to have the same distribution of groups 1, 2, and 3 as noted above, the incidence of all mycobacteria may be as high as 41 per 100,000 discharges (49.2/119,971) and of atypical mycobacteria 10.5 per 100,000 discharges (12.6/119,971).

The average age of the group of patients with *M. tuberculosis* was  $52.5 \pm 18.7$  years, while that of the patients with atypical mycobacteria was  $69.8 \pm 18.4$  years (Table 1).

Of the patients with *M. tuberculosis*, 58.6% were black and 37.9% were white, while 70% of patients with atypical mycobacteria were white and 30% were black.

Of the patients with *M. tuberculosis*, 44.8% were female and 55.2% were male, while 50% of males and 50% of females were found in the atypical group.

Of the patients with atypical mycobacteria, *M. avium* accounted for 70% of all organisms. At least 7 of the 10 patients had pre-existent pulmonary disease. All patients had some clinical manifestations suggestive of disease, although not all had AFB positive smears. Six of the 10 patients had a history of cigarette smoking. Reports of PPD skin testing were available for four pa-

tients and were interpreted as positive in two. One patient had received steroids, and a second patient had undergone splenectomy several years earlier. Otherwise, other than age and conditions noted above, there were no other significant causes for immunocompromise noted. Specifically, there were no cases of acquired immunodeficiency syndrome (AIDS).

## Discussion

### Historical Perspective

The discovery of *M. tuberculosis* by Koch in 1882 was soon followed by the discovery by others of additional species of mycobacteria. The search for hosts (other than man and cattle) of *M. tuberculosis* in the environment resulted in the eventual finding of mycobacteria in soil, water, raw milk, fish, fowl, and reptiles. For over half a century, atypical mycobacteria went unproven as pathogens in man, despite efforts to do so. One cause for the difficulty in establishing the pathogenicity of these organisms was the criteria used — namely that of causing disease in guinea pigs which many of these microbes do not do. Additionally, many atypical mycobacteria are indeed non-pathogenic by today's criteria, and as a whole it has been said the atypical mycobacteria "lie at the edge of pathogenicity."<sup>4</sup> Finally, many healthy people may expectorate non-tuberculous bacilli without evidence of disease.

**TABLE 1 — Comparison of Patients With Atypical Mycobacteria Versus *M. Tuberculosis* Seen at GBMC From January 1, 1981 to December 31, 1985.**

		<i>M. Tuberculosis</i> n=29	<i>Atypical Mycobacteria</i> n=10		p
		Age (years) $52.5 \pm 18.7$	Age (Years) $69.8 \pm 18.4$		<0.02
Race	Black	58.6%	Black	30.0%	N.S.
	White	37.9%	White	70.0%	
	Other	3.5%	Other	0.0%	
Sex	Male	55.2%	Male	50.0%	N.S.
	Female	44.8%	Female	50.0%	



In the 1948 Bergey's Manual, 10 species of mycobacteria were listed, and all had been known for at least 10 years. With the discovery of new antibiotics in the post World War II era, however, more attention was focused on the mycobacteria as intensive culture and sensitivity research was done. In 1954, Timpe and Runyon, working from the Veterans Administration Hospital in Atlanta, Georgia, published a landmark article<sup>5</sup> proposing a new system of classification for the atypical mycobacteria. The Runyon Groups, as they are now known, are based on the growth rate and pigment characteristics of colonies grown on culture media and are composed of four groups: photochromogens, scotochromogens, non-chromogens (all of which are "slow" growers), and rapid growers (Table 2).<sup>6</sup> In general, Groups I and III account for most pathogenic organisms.

**G**roup I, the photochromogens, grow colonies which are white to buff in color, but 6 to 12 hours after exposure to light for at least an hour will develop pigments ranging from brick red to intense yellow. Pathogenic photochromogens include *M. kansasii* and *M. marinum*. Other characteristics of Group I are that colonies are usu-

**While infection or colonization with atypical mycobacteria is apparently common, disease due to these organisms is not.**

ally smooth (although they may be rough like *M. tuberculosis*) and grow slightly more rapidly than *M. tuberculosis* at 37°C. Photochromogens are somewhat pathogenic for guinea pigs and mice.

Scotochromogens, Group II, form a bright yellow or orange pigment when grown in the dark and become more red if exposed to light. These colonies are almost always smooth and grow faster than *M. tuberculosis* at 37°C but slower at 20-25°C. Scotochromogens, such as *M. scrofulaceum*, are not pathogenic for lab animals.

Group III, the non-chromogens, are essentially without pigment regardless of exposure to light, varying in color from off-white to faint yellow. Colonies are smooth, and pathogenicity for lab animals is not uniform. The best known member of this group is *M. avium*.

The rapid growers, Group IV, may appear to be slow growers when initially cultured, requiring 3 to 6 weeks to isolate the primary culture. Subcultures, or cultures grown at 28°C, will be well-developed in 7 to 14 days. Some rapid growers form smooth colonies, other are rough. Some rapid growers, including *M. fortuitum* and *M. chelonae*, are not pigmented, especially when young.

**T**he new method of classification proposed by Runyon was associated with an increase in the recognition of new species. More than 50 mycobacterial species are currently recognized, some of which do not fit exactly into any one of the four original groups. Thus, while Runyon's groups offer a useful system for generalized classification, it is better to refer to each specific organism by name than by group alone. Additionally, organisms within a group may vary in drug resistance or pathological potential.<sup>2, 6, 7</sup>

*General Characteristics of the Atypical Mycobacteria*

While infection or colonization with atypical mycobacteria is apparently common, disease due to these organisms is not. As many as 80% of residents of the Southeastern United States may react to skin

**TABLE 2 — Runyon's Classification of Nontuberculous Mycobacteria<sup>6</sup>**

	<i>Common Species</i>	<i>Colony Pigmentation</i>
<b>GROUP I</b> Photochromogens	<i>M. kansasii</i>	None if grown in dark; bright yellow vs orange or brick red if grown in light
<b>GROUP II</b> Scotochromogens	<i>M. scrofulaceum</i>	Yellow-orange in dark More reddish if grown in light
<b>GROUP III</b> Nonphotochromogens (Battey bacillus)	<i>M. intracellulare</i> <i>M. avium</i>	Weak to none
<b>GROUP IV</b> Rapid growers	<i>M. fortuitum</i> <i>M. abscessus</i>	Usually none

From: Tellis, 1980.



testing with PPD-B (prepared from *M. intracellulare*),<sup>8</sup> but only 2000-3000 cases of atypical mycobacteria are reported annually. Among the possible causes for the rarity of disease caused by such common organisms are: (1) size of the initial inoculum dose (no evidence is available to support this); (2) longstanding colonization evolving into disease (observed in some patients); and (3) immunosuppression of the host (most likely).<sup>4</sup> Impaired bronchopulmonary clearance also plays a key role. At least seven of the 10 patients reviewed at GBMC had pre-existent pulmonary disease. The transmission of atypical mycobacteria is probably via an environmental agent with the lungs serving as a portal of entry. There is no evidence of person-to-person spread.

As with *M. tuberculosis*, the most frequently involved organ system is the lungs. All of the isolates obtained from GBMC patients reported above were from the lungs. Other potential sites for involvement include lymph nodes, skin, bone, genitourinary tract, and joint spaces. Diagnosis of pulmonary disease requires not only culturing of the organism but also repeated positive cultures or isolates obtained from a sterile biopsy. Classical evidence of disease, such as

**The Runyon Groups are based on the growth rate and pigment characteristics of colonies grown on culture media and are composed of four groups.**

fever, weight loss, sputum production, hemoptysis, and chest roentgenogram changes, should be observed.<sup>9</sup> Skin testing, useful with *M. tuberculosis*, is usually not helpful in the diagnosis of atypical mycobacteria. Antigen is available for testing only a few strains. A negative reaction does not rule out infection, and a positive reaction may be caused by previous exposure or overlapping antigenic properties of different mycobacteria. For an individual case, the chest roentgenogram does not distinguish *M. tuberculosis* from the atypical mycobacteria.<sup>10</sup>

Atypical mycobacteria account for 10-33% of all pathogenic mycobacteria.<sup>2,8</sup> In this series, 25.6% of mycobacteria cultured were

atypical. Previous reports have indicated atypical mycobacterial disease is more likely than *M. tuberculosis* to occur in whites and older patients.<sup>8</sup> In this series, 70% were white, while only 37.9% of the patients with *M. tuberculosis* were white. The average age for the two groups was 69.8 and 52.5 years, respectively. Gender has been shown previously to have no bearing between the two groups. Of the patients with atypical mycobacteria, 50% were males, while 55.2% of the *M. tuberculosis* group were males.

*Specific Atypical Mycobacteria*  
*M. avium* complex is composed of *M. intracellulare* and *M. avium*. These two organisms are very similar but separate species, with no significant clinical differences. Therefore, they are usually considered as a complex. They account for approximately 60% of all pathogenic nontuberculous mycobacteria,<sup>11</sup> with 70% noted in this study. Pulmonary involvement is most common. Patients are more likely to be from rural areas, male, >50 years old, with co-existent lung disease which may lend itself to a poorer prognosis than that due to the mycobacterial disease.<sup>12</sup> Pulmonary involvement probably progresses if not treated, but chemotherapy is empiric, as no controlled

**TABLE 3 — Species of Mycobacteria Likely to be Encountered in a Human or Veterinary Diagnostic Laboratory<sup>2</sup>**

	Slow Growers		Rapid Growers
PATHOGENS	<i>M. africanum</i>	<i>M. marinum</i>	<i>M. chelonae</i>
	<i>M. asiaticum</i>	<i>M. paratuberculosis</i>	<i>M. fortuitum</i>
	<i>M. avium</i>	<i>M. scrofulaceum</i>	<i>M. senegalense</i>
	<i>M. bovis</i>	<i>M. shimoidei</i>	<i>M. porcinum</i>
	<i>M. farcinogenes</i>	<i>M. simiae</i>	
	<i>M. haemophilum</i>	<i>M. szulgai</i>	
	<i>M. intracellulare</i>	<i>M. tuberculosis</i>	
	<i>M. kansasii</i>	<i>M. ulcerans</i>	
	<i>M. leprae</i>	<i>M. xenopi</i>	
	<i>M. malmoeense</i>		
NONPATHOGENS	<i>M. gastri</i>	<i>M. terrae</i>	About 25 other species
	<i>M. gordonae</i>	<i>M. triviale</i>	
	<i>M. nonchromogenicum</i>		

From: Wayne, 1985



trials have been held to determine the value of therapeutics in this disease. Of recent importance has been the increase in incidence of *M. avium* associated with AIDS.<sup>13</sup>

*M. kansasii* may account for as much as 20% of mycobacteria in some areas, found most frequently in Kansas, Chicago, Texas, England, Wales, and urban areas. There is a predilection for males and persons 40 to 50 years old. It is antigenically similar to *M. tuberculosis*, conferring about as much protection as does BCG, but it is more difficult to treat. Therapy involves two or three drugs, which is often successful despite *in vitro* tests showing poor sensitivity. Pulmonary disease is most common, and one report<sup>14</sup> indicates 40% of patients may be without symptoms. Since the organism is not usually found in the environment, a positive culture suggests disease, even when colony numbers are small. Curiously, as many as 37% of patients with *M. kansasii* have a history of previous spontaneous pneumothorax.<sup>6</sup>

*M. scrofulaceum* is ubiquitous in nature, but rarely causes disease. When pathogenic, however, it typically causes unilateral lymphadenitis at the angle of the jaw in children 15-36 months of age. Otherwise, these children are healthy with no disease found elsewhere in the body. No evidence of disease is seen in family members either.<sup>2</sup> Very few cases have been reported, but chemotherapy has been successful despite *in vitro* resistance.

*M. marinum* is present throughout nature and is found in warm water, swimming pools, and tropical fish tanks. It causes most of the dermatologic pathology due to mycobacteria — typically localized self-limited skin lesions at the site of abrasions exposed to contaminated sources. Slow lymphatic spread may occur, but deep or disseminated disease is rare, probably because the organism grows best at 27°C.

*M. ulcerans* also causes skin lesions, but unlike *M. marinum*, may proceed to systemic disease. Lesions usually begin on an extremity and advance to the trunk. Patients are often from Africa or the Pacific Islands.<sup>2</sup>

*M. fortuitum* complex is comprised of *M. fortuitum* and *M. chelonae*, the only significant pathogens out of approximately 30 rapid growers. Both are often nosocomial pathogens, having been reportedly associated with dialysis, median sternotomy, augmentation mammoplasty, cooling water in cardioplegia, and continuous ambulatory peritoneal dialysis.<sup>7</sup> This complex accounted for 19% of non-tuberculous pathogenic mycobacteria in 1980<sup>11</sup> and 30% in this GBMC report. *M. chelonae* was first isolated in turtles and is more often associated with pulmonary disease. It is usually resistant to all standard anti-tuberculous therapy. *M. fortuitum* occurs freely in nature and was first isolated in frogs. It is more frequently associated with post-traumatic and post-surgical skin and soft tissue infection. In general, the mortality for this complex is low, although the morbidity may be quite significant.

Other mycobacteria are listed in Table 3.<sup>2</sup>

*Treatment*

Due to the low pathogenicity of the atypical mycobacteria and the lack of evidence of transmission from person to person, respiratory isolation is unnecessary. If the patient is on anti-tuberculous therapy and only an atypical organism grows, the physician may consider stopping therapy and following the patient for changes in clinical symptoms or chest roentgenograms, especially if there is no progression of symptoms or cavitary disease. Many patients will then rapidly clear their sputum of mycobacteria and most likely did not have invasive disease. If, however, there is a progression of disease, therapy may then be instituted. Drug

regimens are variable and often empiric, since extensive controlled studies are not available for most atypical mycobacteria. Treatment usually involves multiple anti-tuberculous drugs. Recent studies have suggested antibiotics not traditionally classified as anti-tuberculous may also be effective. Amikacin has demonstrated *in vitro* activity against *M. tuberculosis*, *M. intracellulare*, *M. kansasii*, and *M. fortuitum*.<sup>15</sup> Cefoxitin is inactive against *M. kansasii*, but has shown variable *in vitro* activity against *M. avium* and *M. fortuitum*.<sup>16</sup> It is an attractive agent due to its low toxicity and side effect profile.

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**Treatment usually involves multiple anti-tuberculous drugs. Recent studies have suggested antibiotics not traditionally classified as anti-tuberculous may also be effective.**

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A high proportion of the *M. avium* complex is resistant *in vitro* to isoniazid (INH), para-aminosalicylic acid (PAS), rifampin (RIF), ethambutol (EMB), and streptomycin (SM), and other agents. But this resistance is often incomplete and may lead to growth abnormalities which could theoretically result in increased susceptibility.<sup>4</sup> Many different recommendations for treatment of *M. avium* have been suggested.<sup>17, 18</sup> In moderately severe cases of pulmonary disease, the 1985 National Consensus Conference on Tuberculosis<sup>13</sup> recommendations include INH, RIF, and EMB for 18-24 months, with SM during the initial 2 to 3 months. For patients with localized *M. avium* pulmonary disease, especially if unresponsive



to medical therapy, surgery is the treatment of choice.<sup>13, 19</sup>

*In vitro* studies of the *M. fortuitum* complex in general show *M. fortuitum* more sensitive than *M. chelonae* to most antimicrobials except erythromycin. Drugs used have included amikacin, tobramycin, cefoxitin, doxycycline, and sulfonamides. Response to therapy is as noted above — difficult to assess due to the variable natural history of the disease and limited number of cases available for study. Antibiotic choice is most reasonably based on sensitivity reports. Treatment failures have occurred despite *in vitro* sensitivity, however, and cures have been reported in the presence of *in vitro* resistance.

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• • •

**EDITORIAL COMMENT:** This study may have erroneously excluded cases of *M. avium* complex associated with AIDS due to method of patient selection. One wonders how many AIDS cases are coded under the secondary opportunistic infections rather than under the broad category of AIDS. If the author had examined the ICD-9-CM cases of AIDS (or those listed under other immunodeficiency states), he might have discovered more atypical mycobacterial infections. ■

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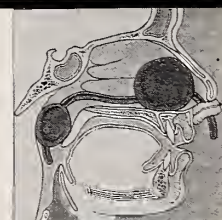
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## CUMULATIVE INDEX



# Hyperparathyroidism and Pregnancy

## *Case Report and Therapy Update*

J. A. Mansberger, M.D., A. R. Mansberger, Jr., M.D.

**H**YPERPARATHYROIDISM and pregnancy is an uncommon combination. Historically, neonatal morbidity and mortality were extremely high in patients who were either untreated or in those who were treated medically. Surgical therapy in the few cases reported has been generally successful. We report a successful surgical outcome on the first reported case associated with the delivery of twins. In addition, the cases reported since Delmonico's review in 1976 are analyzed.

### Case Report

A 32-year-old white woman, gravida 1, para 1, was admitted else-

### Abstract

**T**HE EXACT INCIDENCE of primary hyperparathyroidism during pregnancy is unknown. Isolated case reporting of this entity has been increasing over the past 3 decades and is likely a result of increased awareness, routine use of calcium determinations during pregnancy, and the increased availability of radioimmunoassay for parathormone measurement. Historically, neonatal morbidity and mortality was extremely high in patients who were untreated or in those who were treated medically.

We report a successful surgical outcome on the first reported case of maternal hyperparathyroidism with twins. In addition, the cases reported since Delmonico's review in 1976 are examined and compared to past reviews. A review of the literature reveals that there has been an improvement in neonatal morbidity and mortality for those medically treated, although they continue to remain higher than for those who have had surgical removal of parathyroid pathology during pregnancy.

Improved medical management and earlier diagnosis are probably factors in the improved morbidity. Surgery remains the treatment of choice for most of the patients who are found to have hyperparathyroidism during pregnancy, especially those in whom the diagnosis is established during the first and second trimesters.

where for low back pain and hematuria. The patient was 18 weeks pregnant at the time and passed a renal calculus during that hospital stay. Serum calcium levels obtained on that admission were elevated (12 and 12.5 mgm per deciliter). Her serum PTH level was 141 picograms (high normal of 90). She was subsequently referred to our institution for further evaluation.

Physical exam and history were unremarkable with the exception of her obvious pregnancy, a history of

thymic irradiation during childhood, a history of multiple renal calculi, and the presence of a solitary thyroid nodule. Ultrasound ex-

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amination was consistent with 28 weeks gestation and revealed the presence of twins. Initial laboratory evaluation revealed a calcium of 11.4 mgm/dl, with an albumin of 3.2 gms percent. Initial phosphorous was 2.5 mgm/dl and chloride 106 mgm/dl, for a chloride/phosphorous ratio of 41.  $T_3$  and  $T_4$  levels were within normal limits. Radionuclide scanning and uptake were avoided because of the pregnancy.

The patient underwent neck exploration during her second trimester and a left inferior parathyroid adenoma was found and confirmed by biopsy (Figure 1). Three other parathyroid glands were biopsied and had normal morphology. The thyroid nodule was benign. Post-operatively, the patient had no complications. The serum calcium fell to a low of 7.9 mgm/dl on the third post-op day and had stabilized at 8.1 mgm/dl at the time of discharge. She had no symptoms of hypocalcemia and required no supplemental therapy.

The patient subsequently carried her twins to full term. Two healthy male infants were born normocalcemic and free from any endocrine abnormality.

### Discussion

#### *Effect of Pregnancy on Calcium and Parathyroid Hormone*

Total maternal calcium decreases in the third trimester as a result of hypoalbuminemia, increased fetal utilization, and maternal volume expansion.<sup>1-3</sup> The ionized calcium decreases to a lesser extent or remains normal.<sup>2</sup> PTH increases after the 20th week of gestation and is relatively unreliable as a diagnostic tool during pregnancy. Calcium is actively transported across the placenta even against a diffusion gradient.<sup>1</sup> Because of the high molecular weight, PTH does not cross the placental barrier.

#### *Effect of Hyperparathyroidism on the Neonate*

Since calcium is actively transported across the placenta, ma-

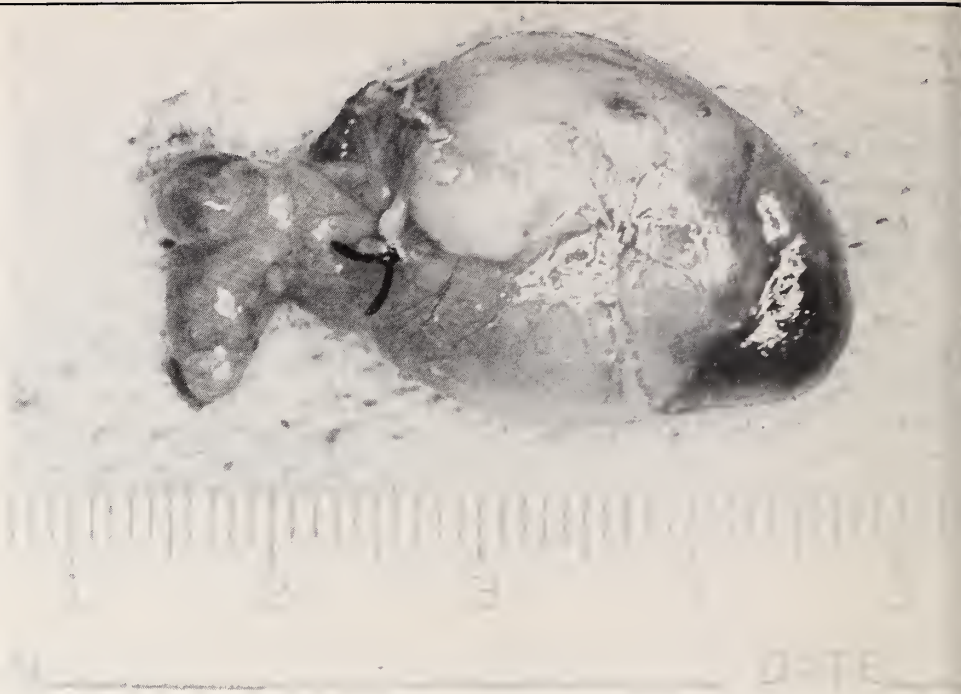


Figure 1 — Parathyroid adenoma removal during the second trimester of gestation.

ternal hypercalcemia results in increased fetal calcium and suppressed parathyroid development in the fetus.<sup>1-3</sup> In neonates born to hyperparathyroid mothers, the suppression of their parathyroid glands results in decreased ability to respond to hypocalcemia via normal negative feedback mechanisms and causes neonatal tetany with the potential for respiratory arrest. This effect may last for 3 to 5 months. Permanent chronic hypoparathyroidism has been reported. Maternal hypercalcemia may thus cause neonatal hypoparathyroidism which can result in significant perinatal morbidity and mortality as evidenced by historical reports.

#### *Review of Therapy*

Ludwig, in a review of hyperparathyroidism and pregnancy from 1930 to 1962, reported findings in 21 women with a total of 40 pregnancies.<sup>5</sup> The overall neonatal complication rate for these patients was 50 percent, with abortions and neonatal death occurring in 31 percent and neonatal tetany reported in 19 percent. The only patient treated surgically had a successful outcome with no complications.

Delmonico, et al reported in 1979 an additional 21 patients with 23 pregnancies treated from 1962 to 1973.<sup>3</sup> Thirteen of these patients (15

pregnancies) were treated medically. Eight patients had their hyperparathyroidism surgically corrected between the 2nd and 6th month of gestation. In the non-surgical group, the complication rate was 80 percent, with a combined stillborn and neonatal death rate of 27 percent and a neonatal tetany rate of 53 percent. In the surgical group, eight patients underwent successful neck exploration. No neonatal deaths or complications were reported, except for one infant who had transient mild hypocalcemia without any associated tetany, a complication rate of 11 percent.

Since Delmonico's review in 1976, an additional 23 patients with a total of 26 pregnancies have been reported. This number includes the present case report. Thirteen of these cases were treated surgically and thirteen by medical management. Two of the patients in the surgical group had unsuccessful neck explorations, a surgical failure rate of 15 percent.<sup>1</sup> They were successfully treated medically for the duration of their pregnancies.

In the 15 patients treated medically, there were no perinatal deaths. Six (40 percent) of the neonates had complications, primarily those associated with hypocal-



cemia and tetany. In the surgical group, there were a total of 11 successful parathyroidectomies. Four patients in this group had previously failed to respond to conservative medical management. There was one neonatal death, a mortality rate of 8 percent. No other neonatal complications are reported. The one neonatal death occurred in the fetus of a mother who underwent emergency neck exploration for hypercalcemic crisis (calcium of 19 mgm percent) and severe pancreatitis which was refractory to medical therapy. A stillborn fetus was delivered in the immediate post-operative period. The mother had a successful postoperative recovery.<sup>6</sup>

In addition to the above cited case report, there have been two additional reports of pregnancy, hyperparathyroidism, and pancreatitis. One patient was reported by Thomason with a calcium of 12 mgm percent discovered in the third trimester of pregnancy.<sup>7</sup> This patient was treated medically with oral phosphates and with satisfactory maternal and neonatal results. Levine reported a patient with severe pancreatitis and calcium in the 15 mgm percent range.<sup>8</sup> After 48 hours of medical therapy for control of hypercalcemia, the patient underwent successful parathyroidectomy with good maternal and fetal outcome.

In addition to the above patient treated with oral phosphates, Monotoro, et al reported two cases in which oral phosphates were used for patients whose hyperparathyroidism was first diagnosed in the third trimester of pregnancy.<sup>9</sup> One had undergone an unsuccessful neck exploration prior to pregnancy. The other presented on her 31st week of gestation. Both responded well to oral phosphate therapy and delivered healthy newborns, though one mother had pre-eclampsia and required cesarean section.

Thus, this analysis of patient reports since Delmonico's review in 1976 indicates that of the additional

26 pregnancies reviewed,<sup>10-14</sup> 13 were managed medically with no neonatal deaths, a marked improvement over the 31 percent reported by Ludwig and the 20 percent reported by Delmonico. The neonatal complication rate (40 per-

cent) does, however, remain high in medically managed patients and is only a slight improvement over the previously reported 50 and 80 percent reported by Ludwig and Delmonico, respectively (Tables 1 and 3).

TABLE 1 — Neonatal Outcome of Medical Therapy Since 1975

	No Complications	Complications	Total
Monotoro, et al <sup>9</sup>	2	1	3
Salem, Taylor <sup>10</sup>	—	2	2
Thomason, et al <sup>7</sup>	—	2	2
Lowe, et al <sup>11</sup>	4	—	4
Leug, et al <sup>2</sup>	1	1	2
Shanghold <sup>1</sup>	2	1	3
TOTAL	9 (60%)	6 (40%)	15

TABLE 2 — Neonatal Outcome of Surgical Therapy Since 1975

	No Complications	Deaths	Complications	Total
Clark, et al <sup>6</sup>	—	1	—	1
Deutsh	1	—	—	1
Dorey <sup>12</sup>	1	—	—	1
Gaeke <sup>13</sup>	1	—	—	1
Levine <sup>8</sup>	1	—	—	1
Molinatti	1	—	—	1
Salem, Taylor <sup>10</sup>	1	—	—	1
Lowe	2	—	—	2
Wilson <sup>14</sup>	1	—	—	1
Present Case	2	—	—	1
TOTAL	11 (92%)	1 (8%)	0	12

TABLE 3 — Comparison of Present and Past Reviews of Neonatal Outcomes, Medical Therapy

	No Complications	Deaths	Complications	Total
1930-1962	19 (50%)	12 (31%)	7 (19%)	38
Ludwig				
1962-1975	3 (20%)	4 (27%)	8 (53%)	15
Delmonico				
1975-Present	9 (60%)	0 (0)	6 (40%)	15
TOTAL	31 (45%)	16 (24%)	21 (31%)	68
Successful Parathyroidectomy				
	No Complication	Deaths	Complications	Total
1930-1962	1 (100)	—	—	1
Ludwig				
1962-1975	7 (87.5)	—	1 (12.5)	8
Delmonico				
1975-Present	11 (92%)	1 (8%)	0	12
TOTAL	19 (90%)	1 (5%)	1 (5%)	21



## **Surgery remains the treatment of choice for most of the patients who are found to have hyperparathyroidism during pregnancy, especially during the first and second trimesters.**

In the surgical group, the only neonatal death occurred in the most critically ill patient of the entire group reported. No other neonatal complications were associated with surgical ablation. For those managed by adequate surgical resection since Delmonico's review in 1976, there was a total neonatal mortality/complication rate of 8 percent (Tables 2 and 3).

### **Summary**

Surgery thus remains the treatment of choice in the vast majority of patients presenting with hyperparathyroidism and pregnancy and reduces the risk of both neonatal and maternal morbidity and mortality.

Medical management with oral phosphates has, however, been shown to be effective in numerous reported cases and should likely be considered the therapy of choice in patients who have a contraindication to surgery and in those presenting or diagnosed late in the third trimester of gestation.

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# Neonatal Pneumococcal Pneumonia

## *Case Report and Literature Review*

Marcia B. Guzzardo, M.D., Marye E. Hacker, B.M.Sc., Gary Walker, M.D.

### Abstract

**A** FULMINANT, FATAL CASE of early onset neonatal pneumococcal pneumonia is presented. An extensive literature review of 18 cases of early onset pneumococcal pneumonia is also discussed. The incidence of early onset *streptococcus pneumoniae* infections seems to occur sporadically and carries a high mortality rate (overall of 72% in our review). Prolonged rupture of membranes was present in only 40% of cases. Mortality rate was highest in those infants of mothers whose membranes were intact. All presented with respiratory distress. The diagnosis of pneumococcal pneumonia should be entertained in any neonate presenting with respiratory distress.

### Case Report

B.C., a 3835 gm black female, was the product of a term pregnancy and vaginal delivery to a 27-year-old gravida<sub>3</sub>, para<sub>2</sub>, Ab<sub>0</sub>, black woman.

Three days prior to delivery, the mother had low grade fever (T

38.4°C), chills, myalgias, and sore throat, but she did not complain of any dysuria or leakage of amniotic fluid. On admission to the delivery room, the mother was in active labor and was febrile with a temperature of 38.4°C orally.

Physical examination revealed a non-tender gravid uterus at term, no evidence of amniotic fluid in the vagina, and intact membranes. Duration of labor was approximately 8 hours. Fetal tachycardia (fetal heart tones 170-190/minute) associated with maternal fever complicated the final 2 hours of the first stage of labor. Very little amniotic fluid was present when the membranes were artificially ruptured.

**I**mmediately upon delivery, the infant experienced respiratory distress. Apgar score was 6/6. The infant was mechanically ventilated

**S** TREPTOCOCCUS PNEUMONIAE as an etiologic agent in neonatal sepsis is not new. While sepsis and pneumonia with Group B streptococcus is much more common and therefore most often suspected, pneumococcal sepsis accounts for up to 5% of all neonatal bacteremia.<sup>1</sup> The case described below is illustrative of the fulminant course that *S. pneumoniae* can take in the neonate. This case and our extensive literature review, which revealed only 18 cases of early onset pneumococcal pneumonia, point out that the diagnosis of pneumococcal sepsis and congenital pneumonia should be considered in any infant (term or pre-term, with or without prolonged rupture of membranes) who presents with respiratory distress in the first few hours of life.

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but at 50 minutes of age began to have recurrent cardio-respiratory arrests. Despite aggressive cardio-pulmonary resuscitation and drug therapy, the infant failed to respond and died less than 90 minutes after birth. Physical examination of the infant revealed no obvious congenital abnormalities. Remarkable physical findings were the infant's shocky appearance and respiratory distress. Antibiotics were not given during the resuscitation efforts. Premortem blood cultures could not feasibly be drawn during the resuscitative efforts.

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**In light of the high proportion of mothers without premature rupture of membranes and the high proportion of infants of normal birth weight, the question of an underlying immunologic defect in the amniotic defense mechanism must be considered.**

---

Arterial blood gas performed shortly after delivery, with the infant intubated and being ventilated with 100% oxygen, showed a pH of 6.694, a PCO<sub>2</sub> of 136.9 mmHg, a PO<sub>2</sub> of 27.2 mmHg, a bicarbonate of 16.7 mmols/l, and a base excess of -23.9 mmols/l. The hemoglobin was 13.1 g/dl. Chest x-ray revealed the lungs to be very poorly expanded, with only minimal lung tissue visible on the left. Laboratory studies performed on cord blood showed a hemoglobin of 14.2 g/dl, a hematocrit of 43.9%, and a corrected white blood count of 3917/mm<sup>3</sup>, with 1% neutrophils, 89% lymphocytes, 8% monocytes, and 2% eosinophils. Hemoglobin elec-

trophoretic pattern on cord blood was FA and on the mother's blood was AA. Postmortem blood culture on the baby was negative, as was the serum antigen screen. Blood culture on the mother, which was drawn after she had received a postpartum intravenous dose of ampicillin, was negative, as was the antigen screen. Cervical culture grew *S. pneumoniae*. Pneumococcal serotypes were not performed.

#### **Pathologic Findings**

At autopsy, no congenital anomalies were identified. Significant pathologic findings were limited to the infant's lungs and placenta. The lungs were heavy; total weight was 100 grams. The visceral pleura was glistening and free of petechial hemorrhages. Slightly frothy, milky secretions were present within the major bronchi. All lobes of the lung had uniformly congested, slightly indurated, cut surfaces and were free of focal lesions. Microscopically, the alveoli were expanded and contained mild to moderate numbers of squamous epithelial cells, consistent with increased in-utero respiratory activity. The alveolar septal capillaries and larger vessels were congested, but alveolar hemorrhages were not present. Diffuse pneumonia involved all pulmonary lobes. The acute inflammatory infiltrate was variable in intensity, with some alveoli completely filled by neutrophils. Necrosis and micro abscesses were absent. Numerous gram positive cocci, many of which were diplococci, were present throughout the inflamed alveolar spaces. *S. pneumoniae* was isolated in pure culture from the right upper lobe.

The placenta was anatomically normal and weighed 850 grams. Focal greenish discoloration of the amniotic membrane was noted. Microscopic examination revealed severe, diffuse chorioamnionitis, with foci of necrosis in the chorionic plate. The chorionic villi appeared mature and were free of in-

flammation. All three vessels of the umbilical cord were acutely inflamed (acute vasculitis). Gram stains were not done, but cultures of both fetal and maternal surfaces of the placenta yielded *S. pneumoniae*.

#### **Discussion**

This infant had congenital *S. pneumoniae* pneumonia. Although postmortem blood culture and serum antigen were negative, the shocky clinical appearance, neutropenia, and fulminant course were all consistent with the diagnosis of overwhelming sepsis. The interesting but unsettled question is whether the infant acquired the infection by hematogenous spread from a concurrent bacteremia in the mother or by ascending spread from the mother's genital tract. There are only four case reports in the literature where both mother and infant had simultaneous pneumococcal infections.<sup>2-5</sup>

**I**n an extensive review of the literature, 37 cases of neonatal pneumococcal sepsis were identified. Fulminant onset of pneumococcal pneumonia within 72 hours of birth was described in 18 of the 37 cases reviewed. These 18 cases (in addition to ours) are reviewed in Table 1. Of these, nearly half (47%) had onset of symptoms within 2 hours of delivery.

Review of these cases, as well as our own case, showed that only 40% of the mothers had rupture of membranes for more than 24 hours prior to delivery. Of those with prolonged rupture, the mortality rate of their infants (34%) was actually lower than the mortality rate for those whose membranes ruptured less than 24 hours prior to delivery (88%). Though small, this review is consistent with Naeye's<sup>6</sup> premise that in most cases of congenital pneumonia, the membranes have appeared to be intact. Eleven of the 13 mothers tested had cervical or vaginal cultures positive for *S. pneumoniae*, an organism not in-



TABLE 1 — Review of Published Reports of Pneumococcal Pneumonia in the Newborn

Source	Year	Race	Hrs. Membranes Ruptured	Gestational Age	Weight (gms)	Age at Onset	Outcome	Cervical Culture	Respiratory Distress
1 Freedman <sup>9</sup>	'28-'35				1360	1 day	death		+
2 Rhodes <sup>3</sup>	'69-'75	C		40 wks		3 days	death		+
3		C		37 wks		1 day	death	+	+
4		C		32 wks		1 day	death	+	+
5 Bortolussi <sup>2</sup>	'70		48	32 wks	1600	6 hr	recovered		+
6	'76		37	28 wks	1300	10 min	death	+	+
7	'76		72	31 wks	1500	2 hr	death	—	+
8	'76		18	36 wks	2680	10 min	death	+	+
9	'76		16	38 wks	2780	2 hr	recovered	+	+
10 Scanlon <sup>10</sup>	'74	C	4		2444	2 hr	death	+	+
11 Tempest <sup>5</sup>	'74		5	40 wks	3100	3 days	death		+
12 Moriarty <sup>1</sup>	'76		24	38 wks	2680	48 hr	recovered		+
13	'76		48		2975	4 hr	recovered		+
14 Hayes <sup>11</sup>	'78		12	38 wks	2480	72 hr	death	+	+
15	'78		15	40 wks	3300	1 hr		+	+
16 Tarpay <sup>4</sup>	'80	C	10	32 wks	1588	1 hr	death	+	+
17 Peter <sup>12</sup>	'80		13	41 wks	3095	18 hr	death	+	+
18 Shanks <sup>13</sup>	'81		48	35 wks	2140	1 hr	recovered	—	+
19 Guzzardo	'85	B	8	40 wks	3835	5 min	death	+	+

cluded among normal vaginal flora.<sup>7</sup> This differs from Group B hemolytic streptococcus which is commonly found as normal vaginal flora in mothers of non-affected infants. In light of the high proportion of mothers without premature rupture of membranes and the high proportion of infants of normal birth weight (50% weighed more than 2500 grams), the question of an underlying immunologic defect in the amniotic defense mechanism must be considered.<sup>8</sup>

One hundred percent of the newborns in our review presented with respiratory distress. Their diagnosis was often confused with hyaline membrane disease and Group B streptococcal sepsis. Although rare, pneumococcal pneumonia in the neonate has a high fatality rate. In our review, 72% died.

### Summary

This small review demonstrates the fulminant course and high mortality rate of pneumococcal pneumonia in the neonate. Mortality rate is highest in infants of mothers with intact membranes, suggesting this to be a congenital disease. From our review, we suggest that the diagnosis of pneumococcal pneumonia be entertained in any neonate presenting with respiratory distress in the first few hours and days of life so that appropriate therapy can be instituted rapidly.

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# Hospital Level and Neonatal Mortality in a High-Risk Population

Charlotte M. Drushel, M.D., M.P.H., Patricia E. White, M.H.Ed., Louise Floyd, R.N., M.S.N.

## Introduction

**N**eonatal mortality rates in Georgia exceed those in the United States. Meeting the 1990 National Objectives for infant mortality is a priority for the Georgia Department of Human Resources (DHR). The provision of prenatal care and regionalization of perinatal services have been cited as factors which may improve pregnancy outcome, especially for high risk patients.<sup>1-6</sup> To increase the utilization of care, the Georgia DHR funds the Maternal High Risk Pregnancy Program (MHRPP), which provides medically indigent pregnant women not eligible for Medicaid and having significant medical risk factors, financial assistance for prenatal care, hospital delivery, and newborn care. The MHRPP uses both the public and private sector to provide this care. The level of hospital of delivery is left to the discretion of the physician providing

## Abstract

**P**renatal care and regionalization of services have been cited as factors which improve pregnancy outcome, especially for High Risk Programs. Twenty-five percent of women in a high risk pregnancy program in Georgia delivered at Level I hospitals. Neonatal mortality rates were 1.5 times higher in women who delivered at a Level I compared to those who delivered at Level II or III. The results suggest delivery in higher level centers should be incorporated into the program.

prenatal care. While the majority of women deliver at Level II and III, nearly one quarter of MHRPP women are delivered at Level I hospitals. Several studies have reported better outcomes for high-risk infants delivered at Level II and III hospitals.<sup>7-10</sup> In this paper, we examine the relationship between level of hospital of birth and neonatal mortality in live born infants of women enrolled in the MHRPP.

From the Georgia Department of Human Resources, Division of Public Health, Women's Health Program, 878 Peachtree St., Atlanta, GA 30309. Send reprint requests to Dr. Drushel, School of Public Health, University of Alabama at Birmingham, Birmingham, AL 35294.

## Methods

A computerized list of women enrolled in the MHRPP for years 1979-1981 who delivered live infants was linked to the Georgia birth-death files using a combination of child's last name, mother's maiden name, child's date of birth, and the mother's date of birth. Matching was performed first by computer, which matched over 80% of the MHRPP women; the remaining were matched manually. A birth certificate was found for more than 99% of the MHRPP enrollees. To verify the quality of the match, a 5% random sample was selected, and both the birth certificates and the MHRPP application forms were examined. (These forms contained additional information including maternal addresses, Social Security Number, and hospital of delivery.) We found a 3% error in the initial match, mainly due to transcription errors; these were subsequently



corrected. On the basis of this sampling, we believe over 95% of the live births to MHRPP participants were correctly linked to the birth-death file.

**H**ospital level was based on hospital of delivery. Hospitals participating in the MHRPP at other than Level I status must be inspected before a higher level is assigned. Hospital level is assigned on the basis of current perinatal care capabilities. State guidelines for assigning hospital level are based on the joint recommendations of the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics.<sup>11</sup> Level I hospitals must be capable of providing care for uncomplicated pregnancies and emergency care for unanticipated complications. Level II and III hospitals provide care for patients with existing or anticipated complications.

**Hospital level is assigned on the basis of current perinatal care capabilities. Level I hospitals must be capable of providing care for uncomplicated pregnancies and emergency care for unanticipated complications. Level II and III hospitals provide care for patients with existing or anticipated complications.**

Neonatal mortality was calculated based on the state linked birth-death files and defined as deaths

**TABLE 1 — Maternal High Risk Pregnancy Program (MHRPP) Participants,\* 1979-1981**

	<i>Number (Percent)</i>	<i>Deaths</i>	<i>Neonatal Mortality Rate</i>
White	4,375 (61.6)	48	11.0
Black	2,724 (38.4)	46	16.9
TOTAL	7,099 (100.0)	94	13.2

\*Those having live births and linked to the birth-death file (see text).

**TABLE 2 — Level of Hospital of Delivery, Neonatal Mortality Rate (NMR),\* and Relative Risk (RR) MHRPP, 1979-1981**

	<i>Level I Number (Percent)</i>	<i>Level II/III Number (Percent)</i>	<i>Total Number (Percent)</i>
White	1,111 (25.4)	3,261 (74.6)	4,372 (100)
Black	706 (25.2)	1,991 (73.8)	2,697 (100)
Total	1,817 (25.7)	5,252 (74.3)	7,069 (100)
Deaths	32	62	94
NMR	17.6	11.8	13.3
RR	1.50 (0.98-2.31)†	1.0	

\*Deaths per 1,000 live births

†95% confidence interval

<28 days old per 1,000 live births. Because there were few births (<1%) and no neonatal deaths to women of "other" racial groups, the analysis by level of care was limited to black and white women. Confidence intervals were calculated using Taylor Series.<sup>11</sup>

### Results

Between 1979 and 1981, a total of 7,099 women were enrolled in the MHRPP and had live births for which a birth certificate could be located. Sixty-two percent were white women, and 38% were black (Table 1). The neonatal mortality rate was 13.2 overall for program participants, 11.0 for white enrollees, 16.9 for black enrollees. The hospital of birth was missing in 30

women, the remaining analyses were performed on the 7,069 remaining births.

About 25% of women in the MHRPP delivered at Level I hospitals (Table 2). There was no difference in the distribution of births by race; 25.4% of white women, and 25.2% of black women delivered at Level I hospitals. The neonatal mortality rate for women delivering at Level I hospitals was 17.6; for those delivering at a Level II or III hospitals, the rate was 11.8. Thus, the risk of a neonatal death was 1.5 times higher if a woman delivered at a Level I hospital.

### Discussion

Women delivering at Level I hospitals experienced higher rates of neonatal mortality than those deliv-



ering at Level II or III hospitals. Race has been found to influence neonatal mortality, but in this study, because the percent of white and black women delivering at Level I hospitals was very similar, we feel race does not contribute to the difference in neonatal mortality. Women delivering at Level I hospitals might be at *lower* risk than those delivering at Level II/III hospitals. Consequently, even equivalent neonatal mortality rates could indicate mortality at Level I hospitals in excess of expected. In Iowa, Hein found higher than expected neonatal mortality rates and preventable deaths at smaller hospitals.<sup>12</sup>

**In this study, women delivering at Level I hospitals experienced higher rate of neonatal mortality than those delivering at Level II or III hospitals. . . . Evaluation of the risk status of patients cared for at Level I hospitals is [therefore] critical.**

The purpose of regionalization is to provide pregnant women and their infants with timely access to appropriate obstetric and newborn care. Regionalization of perinatal services has been credited with contributing to the reduction in neonatal mortality in past years,<sup>3</sup> and both low birthweight and nor-

mal birthweight infants can benefit from improved perinatal care.<sup>7, 8, 13</sup> Level I hospitals should provide services primarily for uncomplicated maternity and newborn patients.<sup>14</sup> Evaluation of the risk status of patients cared for at Level I hospitals is critical. "High risk" patients must be detected early and appropriate referrals made as soon as possible.

Patients in the MHRPP have already been identified as having a current or potential problem which is thought to place them at high risk. The present program guidelines allow delivery of these women at any level hospital. Because this study found that the neonatal mortality rate is lower with delivery at a Level II or III hospital, it would seem prudent that MHRPP women who are selected on the partial basis of potential or actual medical risk should be delivered at a Level II or III hospital whenever possible. The southeastern states have a higher proportion of rural residents than the rest of the nation; a Level I hospital may be the only hospital available. The antepartum risk assessment becomes of utmost importance for proper triaging and the availability and accessibility of Level II or III hospital care and emergency transport must be assured.

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\* \* \*

**EDITORIAL COMMENT:** *It is doubtful that race is not a factor in neonatal mortality, since it influences complications, care, and the prevalence of low birthweight. As there is no description of deaths by weight or cause, no information is available on which to base comment. If it is required that all patients for whom payment is available must be referred to a secondary or tertiary hospital for delivery, local physicians without access to these hospitals probably won't provide prenatal care. This is especially important in rural counties.* ■



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#### BRIEF SUMMARY

##### CONTRAINDICATIONS

There are no known contraindications to the use of sucralfate.

##### PRECAUTIONS

Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

**Drug Interactions:** Animal studies have shown that simultaneous administration of CARAFATE (sucralfate) with tetracycline, phenytoin, digoxin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The clinical significance of these animal studies is yet to be defined. However, because of the potential of CARAFATE to alter the absorption of some drugs from the gastrointestinal tract, the separate administration of CARAFATE from that of other agents should be considered when alterations in bioavailability are felt to be critical for concomitantly administered drugs.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** Chronic oral toxicity studies of 24 months' duration were conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). There was no evidence of drug-related tumorigenicity. A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies were not conducted.

**Pregnancy:** Teratogenic effects. Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

**Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

**Pediatric Use:** Safety and effectiveness in children have not been established.

##### ADVERSE REACTIONS

Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients treated with sucralfate, adverse effects were reported in 121 (4.7%).

Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

##### OVERDOSAGE

There is no experience in humans with overdosage. Acute oral toxicity studies in animals, however, using doses up to 12 gm/kg body weight, could not find a lethal dose. Risks associated with overdosage should, therefore, be minimal.

##### DOSAGE AND ADMINISTRATION

The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

##### HOW SUPPLIED

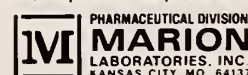
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Issued 1/87

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## ALLAN J. HAMILTON, M.D.

Neurosurgical Resident and Research Fellow,  
Massachusetts General Hospital, Boston, Massachusetts.  
Captain, U.S. Army Reserve.

**EDUCATION** Ithaca College, B.A. (Magna Cum Laude);  
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**RESIDENCY** General Surgical Internship. Neurosurgical  
Residency, Massachusetts General Hospital.

**CONTINUING EDUCATION** Neurology and Neuro-  
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**OUTSTANDING ACHIEVEMENTS** Olsen Memorial  
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Albert Schweitzer Fellowship, International Albert Schweitzer  
Foundation; Harvard Medical School Cabot Prize for Best  
Senior Thesis; recently published article, "Who Shall Live  
and Who Shall Die" in Newsweek Magazine.

■ The work I'm doing in the Army Reserve fits perfectly with my academic research interests in civilian life. The Army is very concerned with the effects of high-altitude cerebral edema, which is a mirror model of cerebral hypoxia, something I deal with every day in our neurosurgical intensive care unit. I couldn't ask for a smoother transition. And that's true for a lot of Reserve physicians. All we really do is change our clothes, not our mindset.

"Some of the projects the Army is undertaking are on the cutting edge of research. For example, I'm currently involved in developing for the Army a prototype of a non-invasive intracranial pressure-monitoring device that we hope will allow us to measure pressure changes as the brain swells—without drilling holes in the skull. If we can get our design to work, such a device could revolutionize high-altitude medicine as well as civilian neurosurgical care.

"The quality of medicine and the caliber of people I've been associated with in the Army Reserve are, without question, equal to civilian hospitals. In fact, I'm giving serious consideration to applying for an active duty academic position in Army Medicine when my residency ends at Massachusetts General. ■■

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## Georgia's New Informed Consent Statute

Robert N. Berg

**“Georgia physicians must now obtain adequate consent as a matter of law or risk exposure to liability arising out of the failure to do so.”**

**I**N VIRTUALLY ALL STATES, under the “Informed Consent” Doctrine, a patient is entitled to bring a lawsuit against a physician who is negligent in disclosing or failing to disclose to the patient the nature of the treatment to be rendered, the risks associated with that treatment, and the available alternatives. In Georgia, however, until recently, the Informed Consent Doctrine was generally viewed to be nonexistent.<sup>1</sup> Rather, under the Georgia Medical Consent Law,<sup>2</sup> a written consent signed by the patient or other authorized person evidencing a “consent to surgical or medical treatment which discloses in general terms the treatment or course of treatment in connection with which it is given” created a *conclusive* presumption of valid consent, in the absence of fraudulent misrepresentations of material fact, thereby defeating any claim of negligence based upon lack of adequate disclosure or consent.<sup>3</sup>

Thus, in Georgia, physicians were not legally obligated to disclose in specific terms and obtain the patient’s consent to a medical or surgical procedure in order to avoid liability. Nor were Georgia physicians required to explain the likely risks inherent in a particular procedure, or the

possible alternatives to that treatment, to escape a finding of negligence.<sup>4</sup> Most Georgia physicians did make such disclosures as a matter of course, but there was no statutory or judicial requirement that they obtain the “informed consent” of their patients.

### Georgia's New Informed Consent Statute

Effective January 1, 1989, however, the Informed Consent Doctrine will be alive and well in Georgia, and in all likelihood will create additional exposure to liability for Georgia physicians. During its 1988 session, the Georgia General Assembly enacted into law Senate Bill 367, which created a new Section of the Official Code of Georgia<sup>5</sup> codifying a form of Informed Consent Doctrine. The following briefly highlights this new Code section:

**Types of Procedures:** The new type of Informed Consent must be obtained in connection with “any surgical procedure under general anesthesia, spinal anesthesia, or major regional anesthesia [or] an aminocentesis diagnostic procedure or a diagnostic procedure which involves the intravenous injection of a contrast material. . . .”<sup>6</sup> Presumably, in cases involving all other types of medical or surgical procedures, the existing rules governing consent (i.e., O.C.G.A. §31-9-6, discussed above) will still apply.

This article was prepared at the request of the *Journal*. Mr. Berg is a partner in the law firm of Vincent, Chorey, Taylor & Feil, Suite 1700, The Lenox Building, 3399 Peachtree Road, NE, Atlanta, Georgia 30326.



## Nature of Informed Consent:

For all procedures of the type described above, the consent of the patient or authorized person must be obtained only after the patient has been informed in general terms of certain specific matters identified in the new law: (i) the diagnosis of the patient's condition requiring the proposed

**Effective January 1, 1989, the Informed Consent Doctrine will be alive and well in Georgia, and in all likelihood will create additional exposure to liability for Georgia physicians. This article highlights this new law.**

treatment; (ii) the nature and purpose of the treatment; (iii) the "material risks generally recognized and accepted by reasonably prudent physicians of infection, allergic reaction, severe loss of blood, loss, or loss of function, of any limb or organ, paralysis or partial paralysis, paraplegia or quadriplegia, disfiguring scar, brain damage, cardiac arrest or death involved in such proposed surgical or diagnostic procedure which, if disclosed to a reasonably prudent

person in the patient's position, could reasonably be expected to cause such prudent person to decline such proposed surgical or diagnostic procedure on the basis of the material risk of injury which could result from such proposed surgical or diagnostic procedure"; (iv) the likelihood of success of the treatment; (v) the practical alternatives generally recognized and accepted by reasonably prudent physicians; and (vi) the prognosis of the patient's condition if the proposed treatment is rejected.

## Legal Effect of Obtaining or Failing to Obtain Informed Consent:

Under the new law, the existence of a written consent, evidencing compliance with the requirements described above, creates a *rebuttable* presumption of valid consent. The law does not indicate the types of evidence which may go to rebut this presumption. Alternatively, the failure to obtain such a written consent does not mean that the physician will be held liable for negligence in failing to disclose the required information or obtain the required consent; it simply means that a physician will not obtain the benefit of any presumption of a valid consent.<sup>7</sup>

**Method of Disclosure:** The new law expressly indicates that the physician who performs the procedure or under whose direct orders the procedure is performed by a nonphysician (referred to in

the new law as the "responsible physician") is responsible for ensuring that the required information is disclosed and that the required consent is obtained. The new law goes on, however, to indicate that the disclosure may be made "through the use of video tapes, audio tapes, pamphlets, booklets, or other means of communication or through conversations with nurses, physician's assistants, trained counselors, patient educators or other similar persons known by the responsible physician to be knowledgeable and capable of communicating such information." The new law further states that, in the hospital setting, any employee of a hospital or ambulatory surgical treatment center who participates in any such conversations at the request of the responsible physician will be considered, for purposes relating to disclosure and consent, to be solely the agent of the responsible physician.<sup>8</sup>

**Exceptions:** The new law lists several exceptions, where compliance is not required with the disclosure/consent provisions of the new law. Among these exceptions are the existence of an emergency; any situation generally recognized by reasonably prudent physicians to involve a procedure not involving a material risk to the patient; any situation where the patient requests in writing that the required information not be disclosed; any procedure



undertaken on the basis of a prior consent, obtained within 10 days of the date of the procedure (or, in the case of in-patient hospital admissions, for a period of 30 days from the date of admission or for the period of time during which the person is confined in the hospital, whichever is greater); or where the surgical or diagnostic procedure was unforeseen or was not known to be needed at the time the consent was obtained.<sup>9</sup>

**Action for Failure to Obtain Informed Contract:** The new law also describes the type of action that must be brought against the responsible physician alleging lack of Informed Consent. Generally, the law requires that the action be brought as an action for medical malpractice, as opposed to a separate action for breach of Informed Consent, as was done in the past. In particular, as required in Georgia for all medical malpractice actions, the patient must have an affidavit from an expert, setting forth that the patient suffered an injury which was proximately caused by the surgical or diagnostic procedure and that the injury was a material risk required to be disclosed under the new law. The plaintiff, to succeed, must also show that required information was not disclosed and that "a reasonably prudent patient would have refused the . . . procedure or would have chosen a

practical alternative to the . . . procedure if such information had been disclosed."<sup>10</sup>

### Conclusion

As is the case with most new statutes, it will take some time — and, in all likelihood, several lawsuits — before the full scope and effect of Georgia's new Informed Consent Doctrine becomes known. It is safe to say at this point, however, that Georgia physicians will need to be much more aware of the specific requirements involved in obtaining a patient's consent to certain types

**“The failure to obtain a written consent . . . means that a physician will not obtain the benefit of any presumption of a valid consent.”**

of surgical or medical treatment. While most Georgia physicians routinely obtained adequate consent in the past, as a matter of course, they now must do so as a matter of law, or risk exposure to liability arising out of the failure to do so.

### Notes

1. See, e.g., *Georgia Hospital Law Manual*, Second Edition (1984), "Consents" at p. 4 ("The informed consent doctrine is dead in Georgia.").
2. O.C.G.A. §§31-9-1 *et seq.*
3. O.C.G.A. §31-9-6(d).
4. See, e.g., *Young v. Yam*, 136 Ga. App. 737, 222 S.E.2d 113 (1975); *Holbrook v. Schatten*, 165 Ga. App. 217, 299 S.E.2d 128 (1983); *but c.f.*, *Spikes v. Heath*, 175 Ga. App. 187, 332 S.E.2d 88 (1985) (Physician required to respond truthfully to specific question raised by patient concerning risks of proposed treatment.).
5. O.C.G.A. §31-9-6.1.
6. O.C.G.A. §31-9-6.1(a).
7. O.C.G.A. §31-9-6.1(b).
8. O.C.G.A. §31-9-6.1(c).
9. O.C.G.A. §31-9-6.1(e).
10. O.C.G.A. §31-9-6.1(d).



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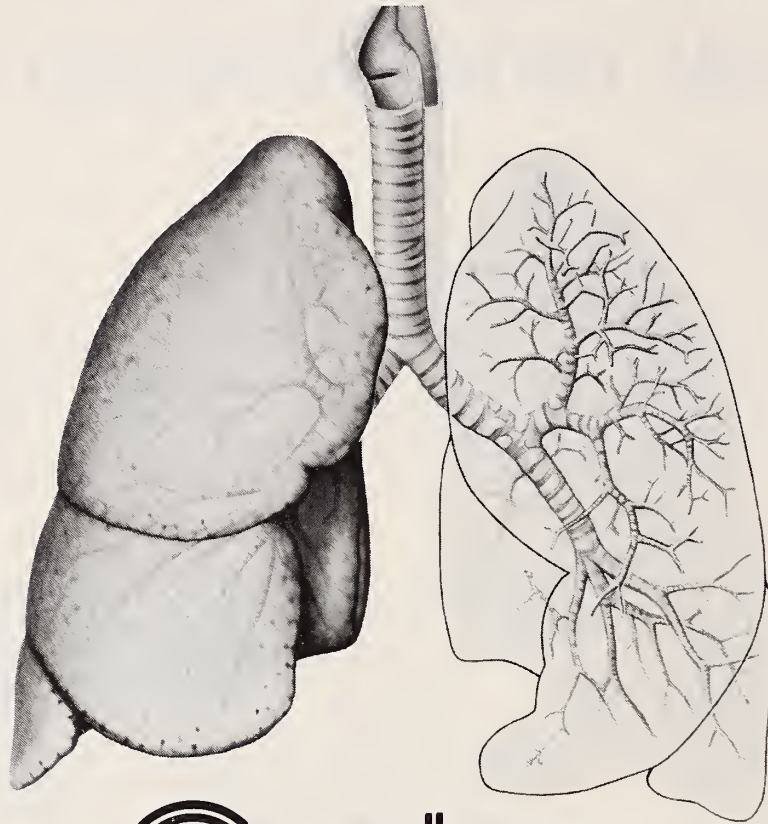
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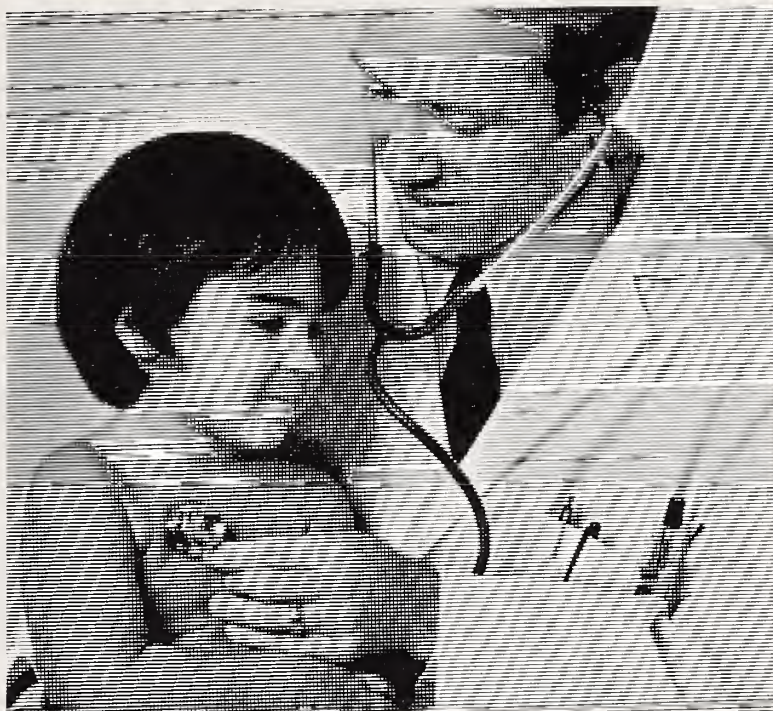
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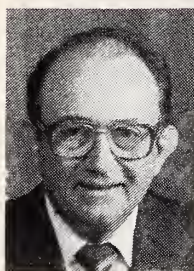
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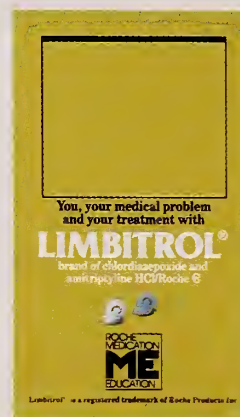
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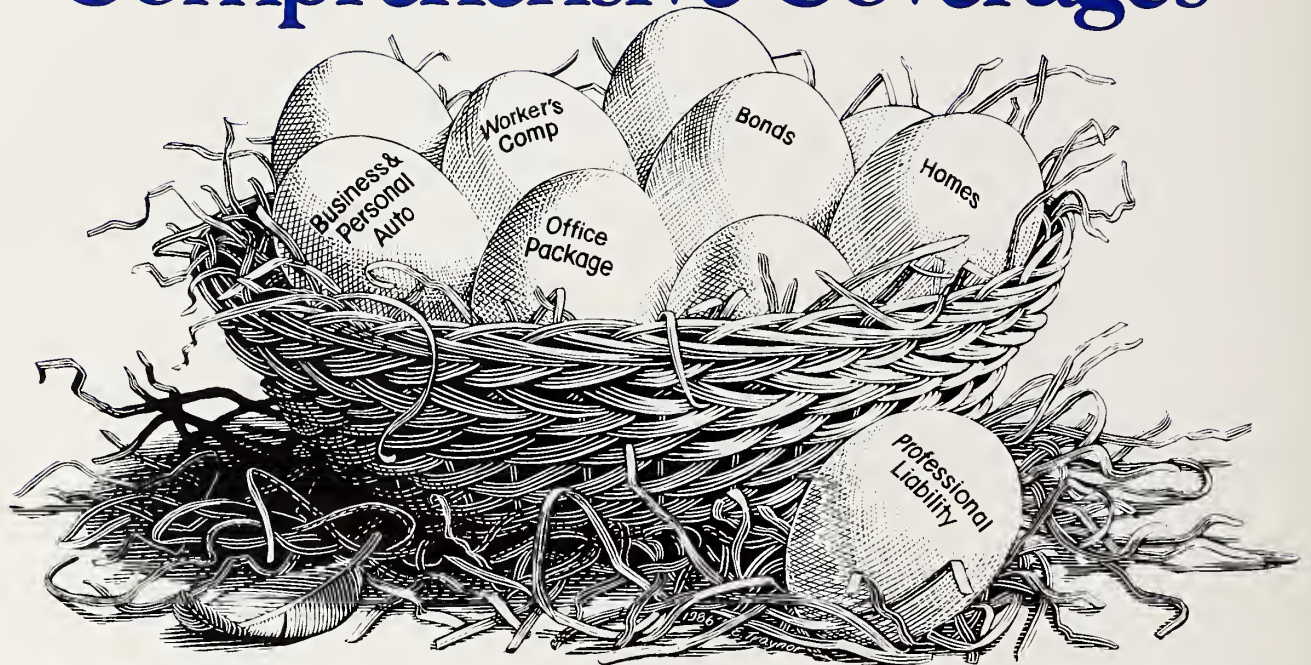
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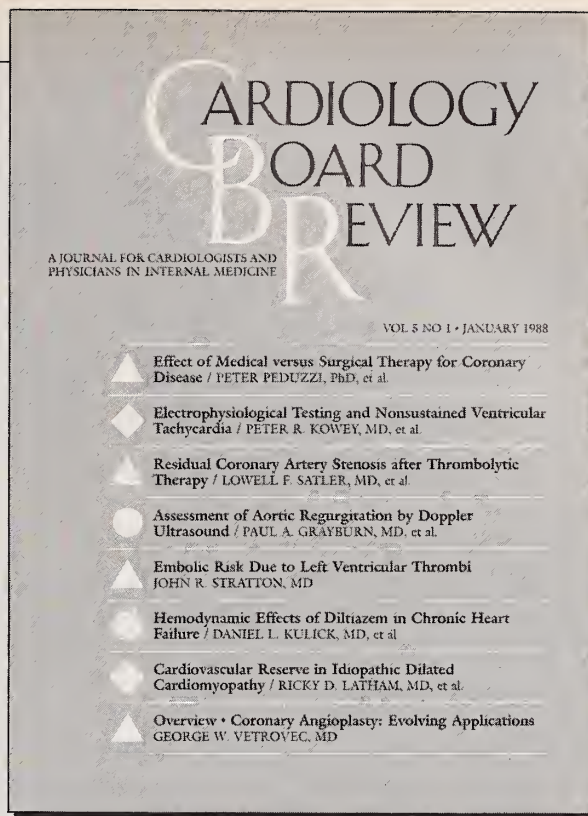


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\* Journals reviewed include: *Circulation*, *American Heart Journal*, *Journal of the American College of Cardiology*, *British Heart Journal*, *Chest*, *The American Journal of Cardiology*, *The New England Journal of Medicine*, *Annals of Internal Medicine*, *American Journal of Medicine*, and *The Journal of the American Medical Association*.



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**COVER**

*The Waving Girl, at dawn, on the Savannah River.*  
Photo by Chuck Rogers, of Atlanta.



### Supreme Court Says Alcoholism Can Be "Willful Misconduct"

**A**lcoholism can now be defined as "willful misconduct," says the U.S. Supreme Court, opening the door for reducing or even eliminating coverage for drug abuse treatment programs.

In its ruling, the court said the Veterans Administration did not violate the Federal Rehabilitation Act by refusing to extend the time limit on education benefits for two "primary" alcoholics. The judges also stated that the court is not the decisionmaker in the argument of whether alcoholism is a disease.

### S&P Downgrades Hospital Bond Ratings

**F**urther proof of the inadequacy of Medicare reimbursement is a new Standard & Poor's report that shows hospital bond ratings being lowered at an accelerating rate.

Since 1983, nearly 22% of S&P's hospital bond ratings have been lowered, while only 5% have been raised. And for not-for-profit hospital bonds, downgrades have exceeded upgrades six to one in the last two years. In 1983, nearly 73% of hospital bonds were A rated; in 1987, however, that percentage had dropped to 65%.

A spokesperson for the New York City firm said downgrades are becoming more prevalent "as Medicare reimbursement lags behind inflation and competition intensifies."

### A Tight Squeeze for Nation's Largest HMO

**M**axicare, the nation's largest publicly traded HMO, has reported a whopping \$60.9 million loss for 1987, with fourth-quarter losses alone totaling \$31.9 million, more than three times what Wall Street's analysts were predicting.

Though the company saw its revenues double during the same year, that gain simply wasn't enough to offset the rise in health care costs and the impact of integrating new acquisitions.

To counterbalance its losses, Maxicare will raise its premiums an average of 15% this year and has already begun to cut \$9 million from its administrative costs. Even so, analysts predict the HMO may eventually be up for sale.

### Nurses Still in High Demand

**D**espite hospitals' efforts to recruit nurses, the nurse vacancy rate for 1987 stands at 11.3%, showing no improvement over the previous year. Nearly 40% of hospitals use temporary nursing personnel, and 10% recruit nurses in foreign countries.

But the most profound effect of the shortage, says the American Hospital Association, is the effect on the delivery of health care services. Temporary bed closures are occurring in 18% of urban hospitals that have a nursing shortage, and many of those have had to limit emergency services. In rural areas, 9.5% of hospitals are turning to temporary bed closures.

In response, AHA has developed a special committee to discuss strategies on the national, state, and hospital levels. Recommendations will be final this summer.

### Hospital Financial Outlook Dims

**H**ospitals are in the middle of a financial slump, says the Healthcare Financial Management Association. Pointing to a new survey of 532 hospitals, HFMA projects that hospitals' median operating margins will drop to 3.3% in fiscal year 1989. Margins currently stand at 4%.

HFMA terms the predicted margins "dangerously low" and blames the drop on Medicare losses, uncompensated care, aging physical plants, the nursing shortage, and the need to keep up with new technology.

### Cut Defense and Defend Health Care

**"**Cut defense spending, not Medicare funding." A new Gallup survey shows three fourths of Americans would think twice about voting for a political candidate who favors cuts in Medicare and Medicaid payments. And 60% of those surveyed favored reductions in defense spending as opposed to entitlement program cuts as a means of balancing a budget.

Where do Americans want to put additional federal funds? Education first and health care second, followed by welfare, transportation, public housing, and defense. The survey also showed that most Americans see inadequate Medicare payments as the precursor to poor quality care.



## Re: Plaudits

Dear Editor,

I continue to enjoy your editorship, and I am delighted that you have a good enough sense of humor to publish Bob Steed's article in the most recent edition. The older I get, the more I find myself reading things like that first. Keep it up!

Sincerely yours,  
Frank Matthews  
Pathologist, Decatur

Dear Editor:

I want to congratulate you on the stand which you recently took in your letter to Dr. Hannay.

I certainly share all the sentiments you expressed in that letter which was recently published in the *Journal of the Medical Association of Georgia*.

Sincerely,  
Stephen F. Gordon, M.D.  
OB/GYN, Atlanta

Dear Editor:

Please accept my deep appreciation for the outstanding articles in the February issue of the *Journal of the Medical Association of Georgia*.

Of course I am very proud of the Old Medical Building and its beautiful picture as well as the story on the history of the Medical College of Georgia by Dr. Spalding.

We appreciate this important interest very much.

Very cordially yours,  
John T. Anderson  
Executive Director  
MCG Foundation, Inc.  
Augusta

Dear Editor:

I read with great interest the article by Betty Castellani in the April volume of the *MAG Journal*, I think it was exceedingly well done, highly appropriate, and an interesting outside viewpoint.

Sincerely,  
Richard W. Cohen, M.D.  
Orthopedic Surgeon, Marietta

## Re: Adolescent Urine Drug Screening

Dear Editor:

This is in response to a Letter to the Editor in your May, 1988, issue regarding the Cobb County Medical Society's (CCMS) Adolescent Urine Drug Screening Program, and the concerns raised by the Georgia Chapter of the American Academy of Pediatrics Adolescent Committee as expressed by Bethanne Jenks, M.D.

The pediatricians' concerns revolve around the issue of involuntary drug testing of adolescents and adults, when the patient thinks he or she is providing a urine sample for an ordinary urinalysis only. This was the reason for the resolution passed by the American Academy of Pediatrics as submitted by their New York Chapter in 1987. I agree that primary care physicians do indeed need to be concerned with this issue. Is the Adolescent Committee advocating informed consent for every laboratory test ordered?

The Cobb County Medical Society Adolescent Urine Drug Screening Program, by its very name, informs what is being tested

for, so that there should be no deception. We encourage parents to test *for proper cause*, when reasonable suspicion exists that illegal drugs are being used by their child. We very much encourage discussion between the parent and the child as to why the test is being requested.

This program has been endorsed by the Georgia Psychiatric Physician Association which represents some 550 psychiatrists in Georgia who are very concerned about informed consent, confidentiality, and drug abuse. It has also been endorsed by the Cobb Area Pediatric Society, the Council for Children, and other organizations.

Laboratory results under the CCMS Program are channeled back to the parent *through a physician* who also has officially ordered the test. The parents are strongly encouraged to seek help for their child if the test comes back positive for the presence of illicit drugs. Since the urine drug screen is offered as a public service, however, there is no physician/patient relationship unless the parent requests help and makes an appointment with a physician.

I appreciate the concerns raised by Dr. Jenks but feel the CCMS program addresses these concerns already. I will be happy to discuss these concerns further with Georgia pediatricians.

Sincerely yours,  
Dirk E. Huttenbach, M.D.  
President, Georgia Council on  
Child and Adolescent  
Psychiatry  
Chairman, Subcommittee on  
Adolescent Drug Abuse, CCMS



## *A View of the Past — A Look to the Future*

***“The successful future belongs to those capable of melding the best of the past with the imagination of the years ahead. It also belongs to those of us willing to take part in the ongoing development of the practice of medicine rather than mouth complaints of how poorly the system is working.”***

*“We are living in a world of permanent change.”*  
Anon.

**W**E MET AGAIN this year. We, those stalwart souls possessed in some inexplicable way with the overriding conviction that if we get together at this “Annual Session of the MAG” one more time we will yet beat down those forces which stand opposed to us and in some manner make order and sense of the future. We seem to do it with such regularity. With such monotonous and droning on regularity. One becomes accustomed to it. To the presentations, the discussions, the rebuttals, the elaborations, the rediscussions, the temerarious suggestions as to solutions. And then the motions. And then the substitutes for motions made — and again the discussions, the elaborations, the rebuttals.

And then the silent prayer uttered, “Oh, Great God, deliver me to more patience, more forbearance, more understanding. Deliver me to the sounding gavel and the cocktail reception.” For this reception has become a part of the modern medical conclave as though it were an agenda item, a

line item budget matter — a necessary and unavoidable accoutrement of this annual gathering of the clan.

It all seems to come as quiet respite to some of us, this matter of attending the meetings that provide the foundation upon which Organized Medicine stands — as respite from the rigid and confining strictures of the scientific world in which we pass our days. We find our relaxation there as did Kipling,

*“I’ve taken my fun where I’ve found it;  
I’ve rogued and I’ve ranged in my time;  
I’ve ‘ad my pickin’ O’ sweethearts,  
And four O’ the lot was prime.”*

To others perhaps it is a tedium of pointless nit-picking. A game of trivia. To all, however, there is the inescapable sense that matters of import are before them.

**A**nd so then, what of the end of it all? Was it indeed as Macbeth said, “It is a tale told by an idiot, full of sound and fury, signifying nothing.”?

Perhaps not. A breeze, fresh and cool and full of hope, blew through the drowsed and listing assemblage this year. It came, not in the cloak of obscure rhetoric, but rather rushed full force from



the prestige granted position of the leader of the band. From the president himself. It came not in the form of nebulous and timorous hints, nor in terms of "I might suggest." It came as concrete "you should." There they were before us. The recommendations that the organizational structure of the organism, of the MAG itself, be reexamined, realigned, and with a semblance of better order and structure, girded more effectively for the tasks that lay ahead.

Those recommendations burst forth to suggest that the past must be flung asunder. Oh, not so dramatic as this perhaps, but at the least reexamined. Looked at with an eye to clarity of vision. Examined, not with callous intellectual lethargy accepted year to year as time passed on into the future, but with a view toward pragmatic change.

The clamor rose from those gathered there as well might have been expected. "What's wrong with the way we have done it?" "I like it the way it is." "Heaven preserve us — Why fix it if it ain't broke?"

**M**ight this poor observer of the passing scene suggest that it's broke? Might he remind us that the splintering effect of ophthalmologists, radiologists, and surgeons pursuing their own

legislative ends without the harmonious involvement of the MAG weakens us all? Might he suggest that when interested and motivated people are placed in positions of leadership with the road of ascendancy to the presidency paved with little in the way of preparatory stones to ready them for the task ahead, *then* it is broke? Might he suggest that when the organizational structure designed to represent American physicians holds within its membership no more than 42% of the practicing American physicians, *then* indeed it is broke? Might he remind us that if "it ain't broke" the axle upon which the wheels turn is wearing thin?

What harm could be done should the old and timeworn — it served us well — what harm done should it be reexamined? Oh, Martin Luther, where are ye? Where the courage to take clear and honest reassessment of the past and question her? Where the vigor of action that placed those 95 theses upon the little church door in Wittenberg?

**C**hange we must, and change we will. The successful future belongs to those capable of melding the best of the past with the imagination of the years ahead. It also belongs to those of us

***‘A breeze, fresh and cool and full of hope, blew through the drowsed and listing assemblage this year. It came, not in the cloak of obscure rhetoric, but rather rushed full force from the prestige granted position of the leader of the band. ’***

willing to take part in the ongoing development of the practice of medicine rather than mouth complaints of how poorly the system is working. Willing to become engaged in the ongoing debate. Capable of winning a few battles with humility and losing a few with dignity. We need the spirit of Theodore Roosevelt: "Far better it is to dare mighty things, to win glorious triumphs, even though checkered by failure, than to take rank with those poor spirits who neither enjoy much nor suffer much, because they live in the gray twilight that knows not victory nor defeat."

CRU



## *The Speech That Should Have Been Made*

Richard W. Cohen, M.D.

**T**HE PROPOSAL to which Dr. Cohen refers in this editorial is Dr. Menendez's suggestion to have the MAG House of Delegates meet twice a year — once in April and again in the fall, in conjunction with MAG's Scientific Assembly, primarily to address legislative issues forthcoming in the Georgia General Assembly. For a complete discussion of this proposal, see Dr. Menendez' President's Report in the Report of Reference Committee A.

**I** am writing this on my return from the House of Delegates meeting in Savannah. It was interesting, the meeting went along very well. It was a good House. There wasn't a lot of controversy. There were some good recommendations and resolutions passed. We heard two insightful and important speeches given by brilliant, important people. We gave out several awards to our friends and to people highly deserving of recognition.

And then it happened! We became comfortable, and, in retrospect, someone, anyone — a leader, a follower, a man, a woman, should have awakened, should have stood up, should have asked the question — why are you here?

Let me paint the scenario. Several months ago, your now Past President, Jack Menendez, stood back and looked at where we were and where we needed to go. He posed, after serious deliberation, some very serious, very well thought out ideas to lead us into the future. They were presented to the Board of Directors. The Board voted overwhelmingly, 90 percent, in favor of his recommendations. This vote was not an uninformed vote. The information had lain on the table for several months.

The propositions were put to the House. And then one lone voice made the motion to "refer to the Board. We don't have enough information to make an informed decision."

**A**nd at that moment it happened. A true void occurred. A hush ensued. A silence. And no one came forth.

And it is that void that I am still feeling in my stomach as I write this article. I ask now the questions, "Why would the House give up its right to vote? Why didn't someone stand up and say 'can't we ask questions'? Were we in such a rush to leave at the end of the day that we didn't want to evaluate and express our views?" No one came forth and said, "Why have I traveled to Savannah, just to

let the Board do the work?" The Board had clearly done its work. The Board had evaluated and had in front of it the proposals and had voted overwhelmingly in the affirmative. I didn't stand up. I didn't say, "Ladies and gentlemen, you came to vote. You came to express your feelings. You came to gain information. You came to provide direction and to make policies for the coming year."

I didn't stand up to say "Ladies and gentlemen, this proposal has great merit. It is not a good proposal; it is a *great* proposal." I did not say, "Why have not dozens of other men and women thought of this proposal and said 'It was my proposal; it was my idea'?" But they had not. Jack Menendez had.

The morning started with our beloved Dr. Jack Rogers "explaining it to us." Explaining what we were up against in the future, explaining who and where the threat was, explaining what action was going to be necessary to survive and to preserve what we have. We heard from our great Lt. Governor Zell Miller how important it is to have clear and concise goals and to speak with one voice. No one stood up! No one stood up to say, "Ladies and gentlemen, this morning we were told why Jack



Menendez's ideas are timely. Let us not wait another day, no less another year, to put ourselves in the position to respond."

I didn't stand up and say what in fact I had said at the Reference Committee, that this proposal was both timely and urgent, that another meeting of the House in the fall is critical to the legislative effort, that it can attract delegates who tend to stay home, that it can concentrate on legislative positions that should be taken by the society, that it should formulate the policies that our legislative committee and team can then act on in a timely manner 6 weeks later when the Georgia General Assembly opens for its 40 days. I didn't stand up and say, "As a Vice President of the Medical Society, I had a fascinating year but no responsibility. The proposals before us are not earth shattering, they do not shake the organization to the core, they are simply sane improvements in small areas whereby the Vice Presidents and the President-elect assume suggested responsibilities to support an ever more complex environment in an ever more burdened society."

No one stood up to ask the questions. No one said, "I came to Savannah to make decisions, not to

be told what to do, but to express my will, to express my intelligence, and to put forth my ideas."

The House had all the information it needed. The proposal had been printed and, in fact, had been distributed over a month prior to the meeting of the House in the Delegates Handbook. There had been a 3-hour Reference Committee hearing and, in addition, I am sure that if anyone from the floor had cared to ask the Reference Committee chairman, he would have been delighted to explain the information that had been placed before it. And lastly, the Reference Committee had not recommended referral back to the Board. The Reference Committee had made a clear and concise decision and put that decision and recommendation before the House.

No one stood up, not even I, to say "Ladies and gentlemen of the House, it is your right and your duty to vote it up or vote it down, not to refer it back to the Board where it had already passed by an overwhelming majority." But that, ladies and gentlemen, is the motion that carried the day.

No one stood up.

I didn't stand up. And for that, ladies and gentlemen, I apologize.

P.S. I leave you with one thought. Did we not all go to

Savannah to be participants? Did we go to Savannah simply to go through the motions. Is the desire "don't make waves, don't create controversy, don't make decisions, don't make policy; let's just come and go as quickly as possible!"?

---

Dr. Cohen is MAG's First Vice President.



# CALENDAR

## JULY

11-13 — *Kiawah Island, SC:*  
**Clinical Obstetrics.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

14-16 — *Kiawah Island, SC:*  
**Update in Gynecology.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

19-23 — *Kiawah Island, SC:*  
**Critical Care Medicine.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

25-27 — *Kiawah Island, SC:*  
**Pediatric Update.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

## AUGUST

8-12 — *Destin, FL:* **Summer Imaging and Interventional Techniques VI.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH 404/727-5695.

11-14 — *Amelia Island:* **Georgia Psychiatric Summer Meeting.** Category 1 credit. Contact James Moffett, MAG, 938 Peachtree St., Atlanta 30309. PH: 404/876-7535 or 800/282-0224.

15-19 — *Atlanta:* **A Comprehensive Board Review in Internal Medicine.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH 404/727-5695.

26-28 — *Kiawah Island, SC:*  
**Georgia Society of Anesthesiologists/South Carolina Society of**

**Anesthesiologists Meeting.** Contact William Hammonds, M.D., 1365 Clifton Rd., Atlanta 30322. PH: 404/321-0111.

## SEPTEMBER

2-4 — *Callaway Gardens:*  
**Georgia Society of Internal Medical/Georgia Chapter, American College of Physicians/Georgia Gastroenterologic Society Joint Meeting.** Category 1 credit. Contact James Moffett, 938 Peachtree St., Atlanta 30309. PH 404/867-7535 or 800/282-0224.

15-17 — *Sea Island:* **Georgia Surgical Society.** Category 1 credit. Contact William McGarity, M.D., 1365 Clifton Rd., Atlanta 30322. PH: 404/321-0111.

19-20 — *Atlanta:* **Menopause Today.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH 404/727-5695.

14-16 — *Atlanta:* **Advances in the Rx and Dx of Cardiovascular Diseases.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH 404/727-5695.

14-16 — *Savannah:* **Neonatology — The Sick Newborn.** Category 1 credit. Contact Div. of Cont. Ed., MCG Augusta 30912. PH: 404/721-3967.

22-24 — *Hilton Head Island, SC:*  
**Frontiers In Nutrition.** Category 1 credit. Contact Div. of Cont. Ed., MCG Augusta 30912. PH: 404/721-3967.

28-29 — *Atlanta:* **Georgia Chapter of the American Academy of Pediatrics Fall Meeting.** Contact Executive

Secretary William Mankin, 4059 Land O'Lakes Dr., Atlanta 30342.

30 — *Atlanta:* **Recent Advances in Clinical Oncology,** Category 1 credit. Contact David Gordon, M.D., 1365 Clifton Rd., Atlanta 30322. PH: 404/727-6761.

## OCTOBER

6-9 — *Sea Island:* **Georgia Orthopaedic Society.** Category 1 credit. Contact David Apple, Jr., M.D., 1938 Peachtree Rd., Ste. 710, Atlanta 30309. PH: 404/352-2234.

11-16 — *Atlanta:* **American Society of Internal Medicine Annual Meeting.** Category 1 credit. ASIM, 1101 Vermont Ave., Ste. 500 Washington, D.C. 20005. PH: 202/289-1700.

## NOVEMBER

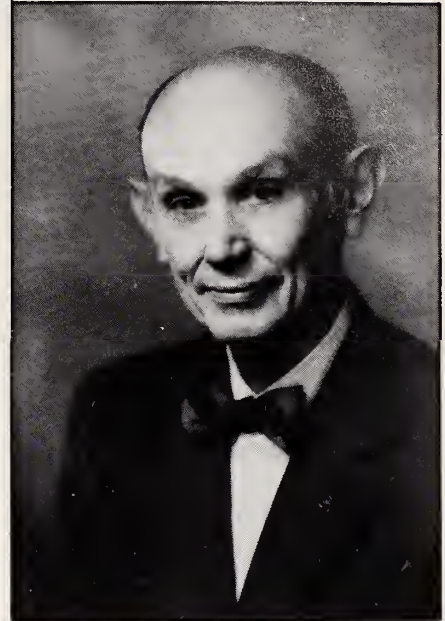
4-6 — *Atlanta:* **Gastroenterology for Primary Care Physicians.** Category 1 credit. Contact Div. of Cont. Ed., Augusta 30912. PH: 404/721-3967.

10-12 — *Atlanta:* **Georgia Academy of Family Physicians Annual Meeting.** AAFP prescribed and AMA Category 1 credit. Contact Camille Day, GAFF, 3760 LaVista Rd., Ste. 100, Tucker, 30084. PH: 404/321-7445 or 800/392-3841.

11-13 — *Sea Island:* **Georgia Obstetrical-Gynecological Society.** Contact Chester Lane, 69 Butler St., Atlanta, 30309. PH: 404/659-0289.

11-13 — *Atlanta:* **Medical Association of Georgia Scientific Assembly.** Category 1 credit. Contact Steve Davis, MAG, 938 Peachtree St., Atlanta, 30309. PH: 404/876-7535 or 800/282-0224.





**T**HE 134TH SESSION of MAG's House of Delegates has just been completed in Savannah. This House is the organization providing the direction of our great medical association and is the democratic expression of the membership's opinion. MAG provides the opportunity for expression of varied opinions, the development of consensus and its effective representation. This is of fundamental import as to the absolute necessity for every Georgia physician to be a member of the Medical Association of Georgia. The activities of the County Medical Societies must deal with the issues of medicine, informing their delegates of their decisions and desires and have these opinions effectively represented in the House of Medicine for our State. Be certain that you are essential to the great issues that are influencing the patients' and the physicians' present and future fate. Do not fail yourself or your profession — get involved and promote membership of your colleagues.

*Joseph P. Bailey, Jr.*



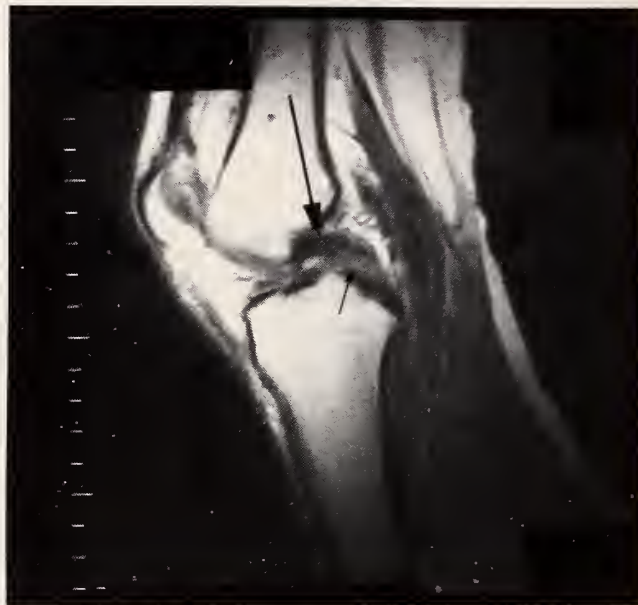
# MR UPDATE

## MRI Advances the Detection of Musculoskeletal Disease

### KNEE EXAMINATION

**HISTORY:** This 44-year-old female recently sustained a knee injury and has clinical evidence of abnormal laxity of the posterior cruciate ligament.

**SCAN:** This parasagittal view near the midline clearly demonstrates avulsion of the posterior cruciate ligament (large arrow). The ligament is normally attached at its femoral origin. Total avulsion of the ligament has occurred near its tibial insertion, the expected position of which is marked by the small arrow. The higher intensity (lighter) material at the tip of the small arrow represents hemarthrosis consequent to the recent injury.



**MRI HIGHLIGHTS:** The ligamentous structures of the knee are routinely well demonstrated by surface coil MRI. Surface coil imaging is essential for the special resolution needed in this area. Surface coil MRI is also useful for demonstrating meniscal injuries. Frank meniscal disruption may be seen and confirmed at arthroscopy. Since the articular surfaces, bone detail, and extra-articular structures are also shown by MRI, MRI is highly competitive with contrast arthrography. MR requires no painful injection and no ionizing radiation. MRI is also the procedure of choice for imaging aseptic necrosis of the hip and other musculoskeletal diseases.



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## NEW MEMBERS

Bentley, Patricia A., Ophthalmology  
— Bartow — 962 Joe Frank  
Harris Parkway, Ste. 201,  
Cartersville 30120

Christensen, Blair, General Practice  
— Georgia Medical — 4700 Hwy.  
80 E, Whitmarsh Island Plaza,  
Savannah 31410

Fowler, Wiley D., Jr., General  
Surgery — Southwest Georgia —  
205 West Main, Colquitt 31727

Kellum, Charles D., Radiology —  
Bibb — 380 Hospital Dr., Ste.  
410, Macon 31201

McBarron, Janet, Bariatrics/General  
Practice — Muscogee — 2920  
Macon Rd., Columbus 31906

McBride, Michael T., Gynecology  
— South Georgia — 305  
University Dr., Valdosta 31602

Neal, Mary J., Pediatrics —  
Dougherty — 920 Third Ave.,  
Albany 31701

Rojas, Ed L., Urology — Gordon  
#2 Hospital Court, P.O. Box 879,  
Calhoun 30701

## PERSONALS

**Robert Causey, M.D.**, retired in  
April after practicing pediatriacs for  
35 years. A graduate of Emory  
University School of Medicine, Dr.  
Causey set up his favorite practice  
in Marietta in 1953.

## DEATHS

**Perry L. Cohn, M.D.**, aged 46,  
Macon neurosurgeon died recently  
of a cerebral hemorrhage. He was  
vacationing in the Caribbean at the  
time.

Dr. Cohn had practiced medicine  
in Macon since 1973 and was  
instrumental in opening Macon's  
Charter Northside Hospital. He was  
a graduate of Emory University and  
the University of Tennessee Center  
for Health Services. After obtaining  
his medical degree in  
neurosurgery, he completed a  
three-year residency at the  
Cleveland Clinic in Cleveland, OH,  
followed by a year's residency in  
England and Canada.

**Charles P. Brooks, M.D.**, of  
Cochran, died recently of an  
apparent heart attack.

Dr. Brooks had practiced family  
medicine in Cochran for the past  
15 years. Prior to moving to  
Cochran, he had maintained a  
practice in Conyers for 15 years  
and was affiliated with the National  
Institute of Health in the research  
field.

He was serving as Chief of Staff  
at Bleckley Memorial Hospital and  
was on the Board of Family  
Practice Physicians.

Survivors include his wife, two  
daughters, and one son.

## LEGISLATIVE SEMINAR

MAG's 1988 Legislative Seminar  
will be held Friday through Sunday,  
August 19-21, at the Jekyll Island  
Club, a Radisson resort hotel.

The Legislative Council has lined  
up an excellent faculty of state  
legislators and other speakers for  
the seminar. They will provide  
insight regarding the legislative/

regulatory/political processes and  
their impact on the practice of  
medicine.

Further details on the Legislative  
Seminar will be sent to each MAG  
member. Registration is limited, so  
if you are interested, contact MAG  
immediately.

## GMCF NEEDS YOUR HELP

**T**HE GEORGIA Medical Care Foun-  
dation plants to initiate a phy-  
sician membership campaign this  
summer which includes a mailing to  
all physicians. Please watch for this  
information and plan to participate  
in this very important peer review ac-  
tivity. Review areas, which in the past  
have been limited to in hospital/pa-  
tient care and federal risk contract  
HMOs, will be expanded over the next  
6-12 months to include Home Health  
Agencies, Skilled Nursing Facilities,  
Hospital Outpatient Departments,  
Ambulatory Surgical Centers, and  
CHAMPUS.

The support and participation of  
qualified, actively practicing physi-  
cians is essential to continuing the  
Medicare and CHAMPUS review  
process within our state. GMCG needs  
your input and assistance for effec-  
tive peer review.

If you have questions or need in-  
formation, please contact Ralph A.  
Murphy, M.D., Medical Director  
GMCF, #4 Executive Park Ave., N.E.,  
Suite 1300, Atlanta, GA 30329-2288;  
800/282-2614 (in Georgia), and 404/  
982-0411.



# New & Dynamic Concepts in Pain Management

Friday, August 19, 1988

Sheraton at St. Johns Place • 1515 Prudential Drive • Jacksonville, FL  
904/396-5100

## AGENDA

8:00-8:15	Introduction/Concepts of Pain Management — Measuring Pain	Dr. J. Green, M.D. <i>Neurologist</i>
8:15-8:45	Anatomy & Physiology of Pain	Dr. A. Bar-Sela, M.D. <i>Physiatrist</i>
8:45-9:10	Pharmacology of Opioids & Methadone — Addiction	Dr. Greg Poff <i>Pharm. D.</i>
9:10-9:45	Multi-Disciplinary Approach to Pain	Dr. A. Bar-Sela, M.D. <i>Physiatrist</i>
9:45-10:00	Break	
10:00-10:30	Chronic Back Pain Therapy	Dr. J. Green, M.D. <i>Neurologist</i>
10:30-11:00	Malignant Pain Therapy	Dr. L. Green, M.D. <i>Oncologist</i>
11:00-11:30	Psychological Aspects of Chronic Pain	Dr. L. Lucas, Ph.D. <i>Psychologist</i>
11:30-11:45	Training Resources on Pain Management	Dr. S. Hickey, M.D. <i>Fellow in Pain Medicine</i> <i>University of Pittsburg</i> <i>School of Medicine</i>
11:45-1:00	Lunch	
1:00-1:30	Trigeminal Neuralgia	Dr. S. Hickey, M.D. <i>Fellow in Pain Medicine</i> <i>University of Pittsburg</i> <i>School of Medicine</i>
1:30-2:00	Round Table Discussion — Management of Chronic Pain	Dr. A. Bar-Sela, M.D. Dr. J. Green, M.D. Dr. S. Hickey, M.D. Dr. L. Lucas, Ph.D.
2:00-2:30	Physiology of Sleep, Sleep Laboratories	Dr. C. Leon-Barth, M.D. <i>Neurologist</i>
2:30-3:00	Proper Prescribing for Insomnia	Dr. J. Green, M.D. <i>Neurologist</i>
3:00-3:30	Break	
3:30-4:00	Local & Regional Blocks in Pain Management	Dr. John Kruse, M.D. <i>Anesthesiologist</i>
4:00-5:00	Clinical Case Presentations Bring your own difficult cases	Seminar Faculty



# New & Dynamic Concepts in Pain Management



Presented By  
**SOUTHEASTERN  
PAIN CLINIC**  
at Jacksonville  
Medical  
Center

Sheraton at  
St. Johns Place  
Jacksonville, Florida  
Friday, August 19, 1988  
8:00 a.m. - 5:00 p.m.

7 CME Credits

**CHRONIC & ACUTE PAIN  
MULTIDISCIPLINARY APPROACH  
TO CHRONIC PAIN  
SLEEP DISORDERS**

*Special Guest Speakers:*

**Dr. Ariel Bar-Sela**  
*Physiatrist  
Director, Houston Pain Center  
Houston, Texas*

**Dr. Steven Hickey**  
*Fellow in Pain Medicine  
University of Pittsburg  
School of Medicine  
Pittsburg, Pennsylvania*

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**Southeastern Pain Clinic**

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904/730-5952

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Jacob Green, M.D.  
Medical Director



# *First General Session*

## *Summary of the Proceedings*

# *134th House of Delegates*

### *April 28 - May 1, 1988*

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#### **Call to Order**

**T**he First General Session of the 134th Annual Session of the Medical Association of Georgia was called to order by the President, Jack F. Menendez, M.D., of Macon, at 7:00 p.m., Thursday, April 28, 1988, in the Regency Ballrooms of the Hyatt Regency Hotel in Savannah, Georgia.

#### **Invocation**

Reverend Jimmy Cason was introduced by Dr. Menendez of the Isle of Hope United Methodist Church in Savannah, who delivered the invocation.

#### **Opening Ceremony**

President Menendez introduced Mrs. John G. Bates who sang the National Anthem (accompanied by Dr. John Watson, Jr.) and led the audience in the Pledge of Allegiance.

#### **Welcome**

Dr. Menendez welcomed all attending the 1988 MAG Annual Session and introduced Dr. Joseph V. Morrison, Jr., President of the Georgia

Medical Society, our host for this year's Annual Session. On behalf of the members of the Georgia Medical Society, Dr. Morrison welcomed the audience to Savannah.

Dr. Morrison introduced Alderman Beth Sheehan, City of Savannah, who expressed a sincere welcome to everyone on behalf of the City of Savannah. Alderman Sheehan thanked the physicians in Georgia for the quality of health care extended to the citizens of Georgia and for their many, many contributions to civic life in the community.

#### **Memorial Service**

Dr. Menendez requested that the audience stand as he read the names of those physician members who had died in the last year: Rudolph Bell, M.D., Thomasville; A. Evan Boddy, M.D., Woodstock; M. B. Bowman, M.D., Albany; Lester A. Brown, M.D., Atlanta; Wilbert O. Brown, M.D., Savannah; Thomas J. Busey, Sr., M.D., Fayetteville; William G. Chambless, M.D., Warm Springs; T. Sterling Claiborne, Sr., M.D., Atlanta; Fred N. Clements, M.D., Adel; William C. Coles, M.D.,





*President Jack F. Menendez, of Macon, called the First General Session of MAG's 134th Annual House of Delegates to order on Thursday, April 28, 1988, at the Hyatt Regency Hotel in Savannah.*

Atlanta; Arthur J. Cook, M.D., Atlanta; Herman Delancy, M.D., Savannah; Richard F. Dickinson, M.D., Rosewell; Ernest B. Dunlap, Jr., M.D., Manchester; C. B. Elliott, M.D., Rome; Eugene Flowers, M.D., Tifton; Wallace M. Gibson, M.D., Eatonton; Abram O. Goldsmith, M.D., Albany; Robert M. Harbin, Jr., M.D., Rome; Wilmer O. Holloway, M.D., Tifton; William U. Hyden, M.D., Trion; Julian A. Jarman, M.D., Decatur; W. F. Jenkins, M.D., Columbus; Hui-Ching Yen Lin, M.D., Atlanta; G. H. Little, M.D., Trion; Leonard Long, M.D., N.C.; Anthony R. Marsicano, M.D., Savannah; W. Roy Mason, M.D., Atlanta; J. Z. McDaniel, M.D., Americus; George F. McInnes, M.D., Augusta; Robert A. Oliver, M.D., Savannah; McLeod Patterson, M.D., Columbus; Robert A. Pumpelly, M.D., Jesup; Joseph L. Rankin, M.D., Atlanta; Henry A. Robinson, Jr., M.D., Reidsville; Charles G. Rogers, M.D., Atlanta; George Schuessler, MD., Smiths, AL; Robert A. Sears, M.D., Macon; Elizabeth A. Singletary, M.D., Augusta; Byron Steele, MD., Calhoun; Daniel J. Urbach, M.D., Atlanta; and James J. Zilis, M.D., Albany.

### **Fifty-Year Members**

The following physicians were honored for having practiced medicine for 50 years or more: Lee H. Battle, Jr., M.D. Rome; Ralph O. Bowden, M.D., Savannah; Curtis H. Carter, M.D., Augusta; Raiden W. Dellinger, M.D., Rome; Roy L. Denney, M.D., Carrollton; Robert H. Gillespie, M.D., Atlanta; J. F. Hackney, M.D., Atlanta; W. Derrel Hazelhurst, M.D., Macon; Katherine M. Hendry, M.D., Blackshear; Lynn M. Huie, M.D., Monroe; Alexander G. Little, Jr., M.D., Valdosta; Robert B. Martin, III, M.D., Cuthbert; J. B. Neighbors, Jr., M.D., Athens; George A. Niles, Jr., M.D., Atlanta; John H. Robinson, III, M.D., Americus; Zachariah S. Sikes, Jr., M.D., Macon; J. Benham Stewart, M.D., Macon; Ann D. Stuckey, M.D., Griffin; Jules Victor, Jr., M.D., Savannah; and Truman W. Whitfield, M.D., Dalton.

### **Life Members**

Life members are those physicians who have supported organized medicine for at least 25 years, and are at least 70 years of age.

Life Membership in the Medical

Association of Georgia as awarded to the following: J. L. Austin, M.D., Griffin; Walter P. Barnes, M.D., Macon; Lee H. Battle, Jr., M.D., Rome; A. S. Batts, M.D., Hawkinsville; W. H. Bedingfield, M.D., Vidalia; Emmett S. Brannon, M.D., Rome; Max M. Blumberg, M.D., Atlanta; Benjamin M. Chambers, M.D., Atlanta; A. B. Conger, M.D., Columbus; P. D. Conger, M.D., Moultrie; R. F. Corpe, M.D., Rome; John B. Crawford, M.D., Barnesville; Albert M. Deal, M.D., Statesboro; W. P. Downey, M.D., Tallapoosa; Robert G. Ellison, M.D., Augusta; William G. Erickson, M.D., Tucker; Don L. Eyler, M.D., Columbus; Charles W. Farmer, Jr., M.D., Newnan; James T. Flynn, Jr., M.D., Moultrie; B. W. Forester, M.D., Macon; Francis M. Gay, M.D., Moultrie; Nathan I. Gershon, M.D., Atlanta; Warren Gilbert, M.D., Rome; John T. Godwin, M.D., Atlanta; Kenneth D. Grace, M.D., LaGrange; W. H. Grimes, Jr., M.D., Atlanta; L. Harvey Hamff, M.D., Atlanta; Thomas S. Harbin, M.D., Rome; J. Frank Harris, M.D., Atlanta; Jack C. Hughston, M.D., Columbus; Louis R. Jelks, M.D., Reidsville; George A. Johnston, M.D.,



## First General Session

Macon; Ben K. Looper, M.D., Canton; Kathryn S. Lovett, M.D., Statesboro; Frank R. Mann, M.D., McRae; John T. Mauldin, M.D., Atlanta; J. T. Mitchell, M.D., LaGrange; A. P. Mulkey, M.D., Millen; Daniel E. Nathan, M.D., Fort Valley; Jule C. Neal, Jr., M.D., Macon; F. Levering Neely, M.D., Atlanta; J. Lee Parker, M.D., Greensboro; G. E. Perkins, II, M.D., Rome; Cecil H. Pirkle, M.D., East Point; Morgan B. Raiford, M.D., Atlanta; R. H. Randolph, M.D., Athens; Thomas E. Rogers, Jr., M.D., Gray; E. A. Roper, M.D., Jasper; Vilda Shuman, M.D., Waycross; Mack Simmons, M.D., Waverly; Charles W. Smith, M.D., Atlanta; F. A. Smith, Jr., M.D., McRae; H. W.



*For his work as a member of the Board of Directors of the Georgia Health Network, Mr. Peter S. Knox, III (center) received a Certificate of Appreciation presented by Dr. Joe Bailey. Shown as well is Mrs. Knox.*



*W. Douglas Skelton, M.D., of Macon, received a Certificate of Appreciation for his valued assistance in the development of AIDS policy and legislation as Chairman of MAG's Task Force on AIDS. Dr. Jack Menendez presented the award.*

Smith, M.D., Swainsboro; William A. Steed, M.D., Augusta; Ann D. Stuckey, M.D., Griffin; James M. Sutton, M.D., Albany; Thomas B. Taylor, M.D., Douglasville; Henry H. Tift, M.D., Macon; R. P. Tucker, M.D., East Point; Herbert D. Tyler, M.D., Thomaston; W. D. Varner, M.D., Columbus; Abraham S. Velloff, M.D., Atlanta; Samuel Victor, M.D., Waycross; E. W. Waldemayer, M.D., Americus; Virgene S. Wammock, M.D., LaGrange; H. S. Weens, M.D., Atlanta; C. Mark Whitehead, M.D., LaGrange; T. W. Whitfield, M.D., Dalton; Virgil B. Williams, M.D., Griffin; and J. J. Word, M.D., Bowdon.



## Certificates of Appreciation

Certificates of Appreciation are presented to those members and others who have been active in Association affairs and through their talents and hard work have made special contributions to medicine and the Medical Association of Georgia.

Certificates of Appreciation were awarded to the following individuals: Jack F. Menendez, M.D., MAG President, 1987-1988; Joe L. Nettles, M.D., First Vice-President, 1987-1988; Richard W. Cohen, M.D., Second Vice-President, 1987-1988; Mrs. Roy W. (Maureen) Vandiver, President, Auxiliary to the MAG, 1987-1988; S. William Clark, Jr., M.D., President and Chairman of the Board, Georgia Health Network; E. C. Evans, M.D., Chairman, Medical Practice Committee, 1985-1987; William M. Headley, M.D., Chairman, Computers in Medicine Committee, 1985-1987; W. Douglas Skelton, M.D., Valued Assistant in Development of AIDS Policy and Legislation; L. Newton Turk, M.D., Dedicated Member of MAG-AMA Delegation; C. Peter Lampros, M.D., Dedicated Member of MAG-AMA Delegation; Mr. Peter S. Knox, III, Member, Georgia Health Network Board of Directors; Lt. Governor Zell Miller; State Senator Frank Albert; State Senator Roy Barnes; State Senator Hugh Ragan; State Senator Harrell Dawkins; State Senator Sallie Newbill; State Senator Pierre Howard; State Senator Terrell Starr; State Senator Bill Fincher; State Senator Tommy Olmstead; State Senator Carl Harrison; State Senator Nathan Deal; State Senator Bud Stumbaugh; House Speaker Tom Murphy; State Representative Ty Carrell; State Representative Dorothy Felton; State Representative Wesley Dunn; State Representative Denmark Groover; State Representative Johnny Isakson; State Representative Bill Lee; State Representative Eleanor Richardson; State Representative Luther Colbert; State Rep-

resentative Betty Jo Williams; State Representative John Greer; State Representative Kenneth Birdsong; State Representative Joe Wood; State Representative George Hooks;

State Representative Jim Pannell; State Representative Tom Wilder; State Representative Billy Randall; and State Representative Pete Robinson.



*Past President of both the MAG and AMA Auxiliaries, Glenda Bates (Mrs. John G.) of Cuthbert, participated in the opening ceremonies of the First General Session by singing the national anthem. She was accompanied on the piano by MAG Past President John D. Watson, M.D.*



*Dr. William M. Headley, of Milledgeville, received a Certificate of Appreciation for his work as Chairman of MAG's Computers in Medicine Committee, 1985-88.*



### Introduction of Guest Speaker

Richard W. Cohen, M.D. of Austell, MAG's Second Vice President, introduced the guest speaker with the following remarks: "Johnny Isakson is a man of many talents with many responsibilities. He juggles what seems to be an incredibly hectic schedule, yet always finds time for his family, friends, and civic responsibilities.

Johnny is probably best known as the Minority Leader of the Georgia House of Representatives. He has represented District 21 in East Cobb County since 1976, and you will find few legislators to match his intelligence and grasp of the complex issues that confront the General Assembly.

In addition to his very important role as Leader of the House Republicans, Johnny is also President of Northside Realty. He plays a key role in the economic vitality of the Metropolitan Atlanta area through his company and such honors as being Chairman of the Cobb County Chamber of Commerce and being named an International Business Fellow.

He is a Past Chairman of the March of Dimes and serves on the Board of Directors of the American Sudden Infant Death Syndrome Institute and the Georgia Unit of the American Cancer Society. Johnny is an active member of the Mt. Zion United Methodist Church, where he is a Board Member, and teaches Sunday School.

For these and many other activities, Johnny has been recognized for his leadership and dedication. He has received the "Outstanding Young Man" Award for Cobb County in both 1976 and 1980; the Distinguished Service Award of the Georgia Rehabilitation Facilities in 1984; and was named "Mr. Cobb County" for 1988.

It is an honor and pleasure to present Johnny Isakson, a true friend of MAG and of so many others."



*Maureen Vandiver (Mrs. Roy), President of the Auxiliary to the MAG, reported to the House about the activities and services provided by the Auxiliary this past year.*

### Introduction of the President-Elect

Dr. Jack F. Menendez stated that "the Office of President of an organization with the magnitude and complexity of the Medical Association of Georgia is an awesome responsibility, and it is most important to have a leader who is equal to that responsibility. It is just such a man who will be our next President, and it is my distinct privilege to introduce the President-Elect of the Medical Association of Georgia, Dr. Joseph P. Bailey, Jr., of Augusta. Dr. Bailey, we look forward to a successful year under your active leadership, and we will wish you good luck throughout the year."

### AMA-ERF Checks

Each year, the American Medical Association-Education Research Foundation distributes funds collected, in large part, by the Auxiliary of the AMA and its various organizations. Mrs. Gwynne Brunt of Atlanta, Chairman of the A-MAG AMA-ERF, and Mrs. Roy W. Vandiver, President of A-MAG, assisted Dr. Watson in the presentation of money raised in Georgia to our four medical schools, as follows: Medical College of Georgia — \$23,208.80; Emory University School of Medicine — \$17,675.04; School of Medicine of Morehouse College — \$6,015.57; and Mercer University School of Medicine — \$8,426.39.



### Report of the Auxiliary

Mrs. Roy W. Vandiver, President of A-MAG, presented the activities and services provided by the Auxiliary this past year. Her written report is in the Unreferred Report section of this *Journal*.

### Recipients of 1988 Medical Association of Georgia Awards

*Hardman Cup:* William H. Foege, M.D. — Atlanta.

*Distinguished Service Award:* James A. Kaufmann, M.D. — Atlanta.

*A. H. Robbins Physician Award for Community Service:* L. C. Buchanan, M.D. — Decatur.

*Civic Endeavor Award:* David A. Wells, M.D. — Dalton.

*Family Physician of the Year:* Lanny Copeland, M.D. — Moultrie.

The Medical Association of Georgia's most prestigious award is the **Hardman Cup** which is presented for "the achievement of anyone who in the judgment of the Association has solved any outstanding problems in public health or made any discovery in medicine or surgery or such contribution to the science of medicine." The 1988 recipient is Dr. William Foege, an epidemiologist.

Dr. Foege, the current Executive Director of the Carter Presidential Center and the Carter Center of Emory University, was, probably more than any other person, responsible for the eradication of smallpox.

Following the establishment in 1966 of the Worldwide Smallpox Eradication Program by the World Health Assembly, Dr. Foege joined the Eradication Program in 1967. Prior to that, he had served as a medical missionary with the Lutheran Church in Eastern Nigeria.

By 1968, 25 million smallpox vaccinations were administered, with measurable results. The fear was, however, that many cases were left unreported, thus continuing the ongoing cycle of contamination. For this reason, Dr. Foege introduced a supplement to the original strategy



Mr. Johnny Isakson, the Minority Leader of the Georgia House of Representatives, was the featured guest speaker at MAG's First General Session on Thursday evening. Mr. Isakson both entertained and instructed the delegates and guests during his speech.



This year's recipient of MAG's coveted Hardman Cup is Dr. William H. Foege (right), an epidemiologist and current Executive Director of the Carter Presidential Center and the Carter Center of Emory University in Atlanta. Dr. Foege was honored for his integral role in the eradication of smallpox throughout the world. He joined the Smallpox Eradication Program in 1967 and introduced a supplement to the original strategy of mass vaccination, called Eradication Escalation, or E<sub>2</sub>.



of mass vaccination called Eradication Escalation, or E<sub>2</sub>.

As the occurrence of smallpox reached a low at the end of the wet season in 1968, the E<sub>2</sub> strategy was to launch an attack to search out, surround, and contain all outbreaks by intensive vaccination efforts during this seasonal low point. It was hoped that this strategy — which had worked well in Eastern Nigeria — would permanently cut the chain of smallpox transmission. Fortunately, the E<sub>2</sub> Program did, indeed, escalate the movement toward eradication.

Dr. Foege became head of the smallpox eradication effort in 1970, and in 1973 he went to India to assist in their eradication efforts. By 1975, due in large part to Dr. Foege's work, India was proclaimed a non-endemic country.

In 1977, Dr. Foege was named Director of the Centers for Disease Control. In that same year, in the country of Somalia, the world's *last* case of naturally occurring smallpox was reported.

The **Civic Endeavor** award is unique among all of the awards given by MAG, and its purpose is to honor those physicians whose motivations find their essential expression in doing good deeds for the public through participation in civic affairs.

The recipient of the Civic Endeavor award for 1988 is Dr. David A. Wells, a family physician from Dalton. Dr. Wells exemplifies the best traditions of the medical profession in his practice of medicine, and at the same time has made significant contributions to the civic life in his community and state.

Dr. Wells has served his profession well in a number of capacities. He is, among other things, Past President and Past Chairman of the Board of the Medical Association of Georgia and Past President of the 7th District Medical Society.

In his community, Dr. Wells was instrumental in establishing the Family Planning Clinic at the Whitfield County Health Department,

and, in the absence of a health director, he assumed the medical responsibility of the Department. He has also served as Chairman of the Whitfield County Board of Health since 1974. He has served on the Board of Directors of the Dalton Chamber of Commerce and helped to found Dalton Junior College. In fact, he was named as the first Chairman of the Board of Dalton Junior College Foundation in 1967.

Dr. Wells has also been active with the youth of Dalton. For over 20 years he served as the team doctor for Dalton High School. He helped organize the Cherokee Boys Estate and served on its first Board. He has spent many hours working with scouts in merit badge studies.

In 1973, the *Daily Citizen News* of Dalton awarded Dr. Wells the prestigious "Man of the Year" award for his time and efforts in civic projects. In 1986, Governor Harris honored Dr. Wells for his "exemplary leadership and unselfish efforts on behalf of family planning services in Georgia."



*Dr. David A. Wells, a family physician from Dalton (right), received MAG's Civic Endeavor Award for his many contributions to the civic life in his community and state. Not only active in the MAG, Dr. Wells was instrumental in establishing the Family Planning Clinic at the Whitfield County Health Department. He has served on the Board of Directors of the Dalton Chamber of Commerce and helped to found Dalton Junior College.*



Dr. Wells' civic activities represent physicians at their finest, serving humanity not only through medicine but in his community activities.

The **Distinguished Service Award** is presented for "distinguished meritorious service which reflects credit and honor on the Association." The recipient of the 1988 Award is Dr. James A. Kaufmann, of Atlanta. An internist, he is also Speaker of the House and Chairman of the Legislative Committee for the Medical Association of Georgia.

Dr. Kaufmann has served the medical needs of Georgians for more than 35 years. He has served his community, state, nation, and profession in many ways. Recognition for his achievements resulted in MAG awarding him the Distinguished Service Award in 1970 and 1974, and the Aven Cup Award in 1981.

Dr. Kaufmann's contributions in the field of human relations are unique. His work has been recognized by the National Association for the Advancement of Colored People who awarded him the 1987 Humanitarian Award.

In the field of politics, Dr. Kaufmann's activities are equally impressive. He has been awarded a Certificate of Commendation by the Georgia General Assembly nine times in as many years. Moreover, he has served on the Governor's staff under Governors Carter and Busbee.

On all levels, Dr. Kaufmann holds a variety of membership positions and offices in numerous political organizations. Through these memberships and activities, Dr. Kaufmann has been instrumental in influencing legislation and policies which embody the philosophy of the medical profession.

Dr. Kaufmann also lends his talent to organizations concerned with the welfare of mankind such as the National Rehabilitation Association, the National Jewish Welfare



*Dr. James A. Kaufmann (right) is presented with MAG's Distinguished Service Award by Dr. Menendez for his service to his community, state, nation, and profession. Recognition for his achievements resulted in his receiving this award in 1970 and 1974, and the Aven Cup Award in 1981. He received the 1987 Humanitarian Award from the NAACP and has served on the Governor's staff under two governors. Dr. Kaufmann holds a variety of membership positions and offices in numerous political organizations.*

Board, the Anti-Defamation League, the Christian Council of Metropolitan Atlanta, and the United Way.

The Medical Association of Georgia is proud of Dr. Kaufmann's accomplishments and honored to have him as a member of the Association.



The **A. H. Robins Physician Award for Community Service**, established in 1961, provides recognition to physicians for the many and varied services above and beyond the call of duty which they render to their respective communities. A. H. Robins makes the award available in the belief that members

of the health team should use all appropriate ethical means of improving and enlarging the stature of the physician, as a professional and a participant in community life.

MAG's first recipient of the A. H. Robins Award for Community Service is Dr. L. C. Buchanan, a general surgeon from Decatur. Dr. Bu-

chanan has been an active participant in organized medicine. He is Past President of the DeKalb Medical Society and the 5th District Medical Society, and is past Speaker of the House of the Medical Association of Georgia. He is a member of the American Medical Association, the Southern Medical Association, the Southeastern Surgical Congress, and the Georgia Surgical Society.

His contributions to his community have been equally outstanding. He has held membership positions on: the Board of Directors of the DeKalb County Unit of the American Cancer Society; the Georgia Regional Medical Program from District 4; and the Governor's Nominating Commission for Medical Appointments to the Board of Human Resources.

Dr. Buchanan has been a member of the Decatur Rotary Club since 1954 where he has served as Director and member of various committees. He belongs to the North Decatur United Methodist Church where he served for a number of years on the Board of Trustees and as Chairman of the Board. He is a voluntary surgical consultant for the Methodist Children's Home in Decatur, and a founder of the Hospice of the Good Shepherd.

The Medical Association of Georgia is extremely proud of the many contributions Dr. Buchanan has made to the medical profession and his community.

Dr. Howard Vigrass of Columbus, President of the Georgia Academy of Family Physicians, presented the **1988 Family Physician of the Year** award to Dr. Lanny Copeland of Moultrie.

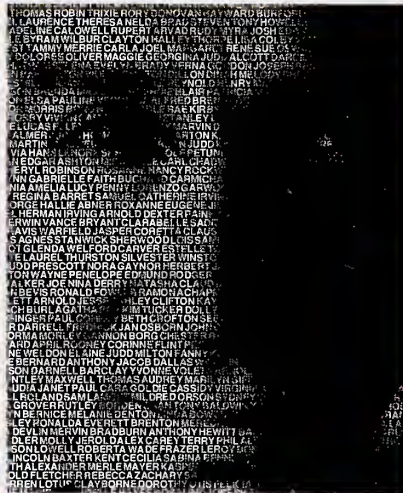
Dr. Copeland is a senior partner in a two-man family practice group in Moultrie. He is Board Certified Family Physician and a clinical assistant professor at the Medical College of Georgia. He serves as a preceptor for medical students, which is a core clerkship for medical students rotating on a monthly basis.



*Dr. L. C. Buchanan, a general surgeon from Decatur, is MAG's first recipient of the A. H. Robins Award for Community Service. Established in 1961, this award provides recognition to physicians for the many and varied services above and beyond the call of duty which they render to their respective communities. Dr. Buchanan has been very active in organized medicine at both the county and state levels. He has held many outstanding positions in his community as well. He is a voluntary surgical consultant for the Methodist Children's Home in Decatur and a founder of the Hospice of the Good Shepherd.*



**(PROPRANOLOL HCl)**  
LONG ACTING CAPSULES 60, 80, 120, 160 mg





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...like the more than one million patients who have received **INDERAL® LA**.

In a recent survey, 4,120 participating physicians gave us their views<sup>1</sup> on **INDERAL LA** in the treatment of hypertension, angina and migraine.

## **INDERAL LA is their preferred beta blocker**

...of the nearly three out of four physicians responding to the questionnaire, an impressive 97% rated **INDERAL LA** good to excellent for overall performance. Virtually all cited efficacy, tolerability, long-term cardiovascular protection and once-daily convenience as important factors in their choosing to prescribe **INDERAL LA**.

## **INDERAL LA promotes patient compliance**

...Virtually every responding physician rated patient satisfaction with **INDERAL LA** to be as good as, or better than, other beta blockers.

Like conventional **INDERAL** Tablets, **INDERAL LA** should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree and bronchial asthma.

**ONCE-DAILY**  
**INDERAL® LA**  
 (PROPRANOLOL HCl)  
 LONG ACTING CAPSULES  
 60, 80, 120, 160 mg

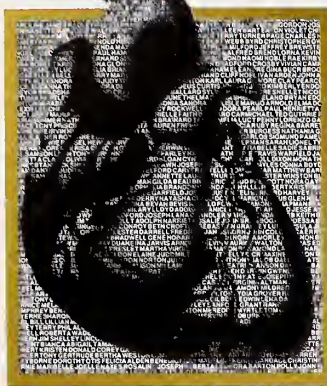
# The one you know best keeps looking better

Please see next page for brief summary of prescribing information.

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 ARCUS RHODA JEREMY  
 LIAN FLOYD ELLIOTT HAR  
 Y MYRA JOSH EDWARD  
 AMMY MERRIE CARLA JO  
 LEY IRIS STEPHANIE CHA  
 A JESSICA BERNARD MA  
 E BLAIR PATRICIA MIL  
 ANNON MORRIS BOND  
 AHAM ELEANORE GIN  
 MORE CLAY PEARCE G  
 NICOLE PETUNIA HA  
 LEE CHERYL ROBINS  
 RVIN HUNTER NEVIN  
 RTLAND COLEMAN  
 ER PAINE JANE SH  
 AWLEY KATHERINE  
 EIRMA MYLES JULI  
 INETTE LAUREL TH  
 RANDALL PHYLLIS  
 RION JULIUS GLEN  
 JESSE ASHLEY CLIF  
 ANCHE ROBIN JACO  
 RK NOAH STEWART  
 ORINNE FLINT PRES  
 RON NORTON JULIE  
 SHIRLEY HARPER PE  
 OLDIE CASSIDY VIRGI  
 LYDIA GROVER RUTL  
 SIBYL NOEL HUMPHR  
 L BILL LILLIAN MARLE  
 ADE FRAZER LEROY DO  
 SMEREDITH ALEXAND  
 ES MOND TONY HILARY  
 ERTA LEONORA BART  
 ENNIS CULLEN TABIT  
 RENDAN GUNTHER E  
 MARIO JAYNE MELIS  
 SPER VITO NICHOLA  
 Y JONATHAN SALLY  
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 AT DIANE JENNIFER LE  
 LLEEN DWIGHT MITCH  
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 ANSON ANDREW GALL  
 ER ROXANNE ASHBY HAR  
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 JOSEPH PAGE JULIE REX REY  
 LEONA RUDY MARCUSS LOAN B  
 RA DONNA CRAIG ANNE EL MER F  
 HAM ADELINE HALLEY MILFORD DE  
 ON PRISCILLA WILSON RUPERT HARF  
 ATH STEVEN BRONSON JEAN PETER DIAN  
 NE LORNA ROBERTA NOBLE TOM SABINA  
 T MIA BARTLETT BEAU DINAH JIM FRITZ DI  
 NE CECILIA TAMARA BEN ROSABELLE JU  
 LE SIMPSON BERNARD ERROL CORETTA  
 VERETT MARGOLENA LORENZO CLIFF R  
 N MARTIN THOMAS TONY COLEMAN LUCIL  
 DEN REBECCA COURTNEY NICOLE BREWS  
 ER RHONDA TURNER MADELINE ELLEN MO  
 OWLER JANET TONY THOMAS ROBERTSON  
 TROBIN HARDEN BRETT NEIL BORDEN OT  
 WATSON GEORGIA BARCLAY ODESSA  
 ADWICK APRIL TODD ARDEN LAUR  
 A MABEL SHERWIN PAT IDA GINA  
 ARD ARNOLD HILLIARD SILVES  
 ORA DONAHUE EGAN MURRA  
 AMDEN EDNA MILES ALBER  
 RUSSEL AUDREY ELI DEWE  
 RNOLD TONY WILFRED CI  
 DAM TYSON LARISSA A  
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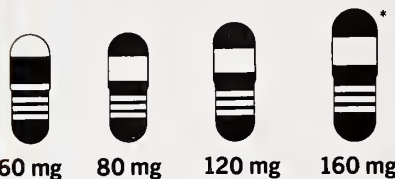


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(PROPRANOLOL HCl) LONG ACTING CAPSULES 60, 80, 120, 160 mg

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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

**INDERAL<sup>®</sup> LA** brand of propranolol hydrochloride (Long Acting Capsules)

**DESCRIPTION.** INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

**CLINICAL PHARMACOLOGY.** INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure, and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

**INDICATIONS AND USAGE.** **Hypertension:** INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

**Angina Pectoris Due to Coronary Atherosclerosis:** INDERAL LA is indicated for the long-term management of patients with angina pectoris.

**Migraine:** INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

**Hypertrophic Subaortic Stenosis:** INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

**CONTRAINDICATIONS.** INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

**WARNINGS.** **CARDIAC FAILURE:** Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

**IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE,** continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

**IN PATIENTS WITH ANGINA PECTORIS,** there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

**Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS.** INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

**MAJOR SURGERY:** The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

**DIABETES AND HYPOGLYCEMIA:** Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

**THYROTOXICOSIS:** Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing  $T_4$  and reverse  $T_3$ , and decreasing  $T_3$ .

**IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME,** several cases have been reported which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

**PRECAUTIONS. GENERAL:** Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be aware that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return in increased intraocular pressure.

**CLINICAL LABORATORY TESTS:** Elevated blood urea levels in patients with severe heart disease elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

**DRUG INTERACTIONS:** Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL (propranolol HCl) is administered. The add catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncope, ataxia, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure, or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, phenobarbital, and rifampin accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and lidocaine have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected  $T_3$  concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

**CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY:** Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

**PREGNANCY:** Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**NURSING MOTHERS:** INDERAL is excreted in human milk. Caution should be exercised with INDERAL administered to a nursing woman.

**PEDIATRIC USE:** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS.** Most adverse effects have been mild and transient and have required the withdrawal of therapy.

**Cardiovascular:** Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

**Central Nervous System:** Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

**Gastrointestinal:** Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

**Allergic:** Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching sore throat, laryngospasm and respiratory distress.

**Respiratory:** Bronchospasm.

**Hematologic:** Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

**Auto-Immune:** In extremely rare instances, systemic lupus erythematosus has been reported.

**Miscellaneous:** Alopecia, LE-like reactions, psoriasisiform rashes, dry eyes, male impotence, Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

**DOSAGE AND ADMINISTRATION.** INDERAL LA provides propranolol hydrochloride sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL Tablets. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

**HYPERTENSION—Dosage must be individualized.** The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

**ANGINA PECTORIS—Dosage must be individualized.** Starting with 80 mg INDERAL LA once daily dosage should be gradually increased at three- to seven-day intervals until optimal response obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (WARNINGS).

**MIGRAINE—Dosage must be individualized.** The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

**HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.**

**PEDIATRIC DOSAGE—** At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

\*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

**Reference:**

1. Data on file, Ayerst Laboratories.

D7295/188

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Dr. Copeland completed his training at the University of Louisville School of Medicine and his internship at Marion County General Hospital, where he was named Intern of the Year.

His activities with the Georgia Academy of Family Physicians include being President in 1985-86; Chairman of the Board in 1986-87; chairman of several committees; a member of the Board of Directors since 1980, and a member of the House of Delegates. He was named GAFF's Family Medicine Educator of the Year in 1985.

### Adjournment

Following several brief announcements, Dr. Menendez adjourned the First General Session at 10:00 p.m.

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*The 1988 Family Physician of the Year is Dr. Lanny Copeland (right) of Moultrie. Dr. Howard Vigrass of Columbus, President of the Georgia Academy of Family Physicians (left) presented Dr. Copeland with this award. Dr. Copeland is a clinical assistant professor at MCG and serves as a preceptor for medical students. He has been active with the GAFF and was named its Family Medicine Educator of the Year in 1985.*



# *First Session House of Delegates*

## *Thursday, April 28*

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**T**HE FIRST SESSION of the MAG House of Delegates was called to order by the Speaker of the House, James A. Kaufmann, M.D., at 7:30 p.m., Thursday, April 28, 1988, in the Regency Ballrooms of the Hyatt Regency Hotel, Savannah, Georgia. Jack A. Raines, M.D., Columbus, served as Vice Speaker of the House.

The Speaker called for a report from the Credentials Committee which was given by Dr. Milton I. Johnson. Dr. Johnson reported that 137 delegates representing 42 component county medical societies were in attendance and accordingly, announced that a quorum of the House of Delegates was present.

### **Delegate Attendance**

Donald C. Abele, M.D.; Bruce S. Allen, M.D.; Robert H. Anderson, Jr., M.D.; Thomas J. Anderson, Jr., M.D.; Catherine S. Andrews, M.D.; John S. Antalis, M.D.; Harold Asher, M.D.; Phil C. Astin, Jr., M.D.; James E. Averett, Jr., M.D.; Ivan A. Backerman, M.D.; Joseph P. Bailey, Jr., M.D.; C. Robert Baisden, M.D.; Philip N. Bannister, M.D.; William H.

Barfield, Sr., M.D.; Needham Bateman, M.D.; James F. Beattie, Jr., M.D.; Sidney A. Bell, M.D.; William H. Biggers, M.D.; H. Duane Blair, M.D.; Allan C. Bleich, M.D.; David C. Bosshardt, M.D.; Clinton E. Branch, Jr., M.D.; Spencer S. Brewer, Jr., M.D.; Larry Brightwell, M.D.; Rodney M. Browne, M.D.; William Brooks, M.D.; Billy D. Burk, M.D.; Robert A. Burns, M.D.; William B. Burns, Jr., M.D.; E. Napier Burson, Jr., M.D.; Leon H. Bush, M.D.; Louis G. Cacchioli, M.D.; Donald H. Campbell, M.D.; Frank E. Carlton, M.D.; Albert A. Carr, M.D.; Curtis H. Carter, M.D.; Robert Glenn Carter, M.D.; Al Bleakley Chandler, M.D.; Joseph Citron, M.D.; Thomas S. Claiborne, Jr., M.D.; S. William Clark, Jr., M.D.; Teresa E. Clark, M.D.; Arturo Corso, M.D.; Marvyn D. Cohen, M.D.; Michael Joseph Cohen, M.D.; Richard W. Cohen, M.D.; Chappell A. Collins, Jr., M.D.; William C. Collins, M.D.; Terrence J. Cook, M.D.; L. T. Crimmins, M.D.; Richard Culp; David W. Dalrymple, M.D.; Alfred L. Davis, Jr., M.D.; Floyd E. Davis, M.D.; H. G. Davis, Jr., M.D.; Sammie Dixon, M.D.; M. Julian Dutera, Jr., M.D.; J. W. Estes, M.D.; J. Patrick Evans, M.D.; Louis H.



Felder, M.D.; Daniel S. Ferguson, M.D.; Sumner Fishbein, M.D.; Gilbert J. Foster, Jr., M.D.; Greg Foster, M.D.; Henry A. Foster, M.D.; David J. Frolich, M.D.; Stefan H. Fromm, M.D.; J. Harper Gaston, M.D.; John A. Goldman, M.D.; Kenneth L. Goldman, M.D.; Robert D. Gongaware, M.D.; Joe L. Griffeth, M.D.; H. A. Gussack, M.D.; Margarita Guzman, M.D.; Michael A. Haberman, M.D.; Thomas A. Haltom, M.D.; O. Emerson Ham, Jr., M.D.; Carl V. Hancock, Jr., M.D.; Thomas A. Hanson, M.D.; William R. Hardcastle, M.D.; J. Rhodes Haverty, M.D.; William McKendree Headley, M.D.; William C. Heard, M.D.; Irving D. Hellenga, M.D.; E. V. Herrin, M.D.; William E. Holladay, Jr., M.D.; John A. Hudson, M.D.; John Hunt, M.D.; Mark C. Hutto, M.D.; Eugene H. Jackson, M.D.; Joseph M. Jackson, M.D.; Milton I. Johnson, Jr., M.D.; Fleming L. Jolley, M.D.; George Jones, M.D.; William B. Jones, M.D.; Fareed Z. Kadum, M.D.; James A. Kaufmann, M.D.; Ferdinand V. Kay, M.D.; Ellis B. Keener, M.D.; William F. Keeton,



*The First Session of MAG's 134th House of Delegates was called to order by James A. Kaufmann, M.D., Speaker of the House. MAG President Jack F. Menendez is on the left.*





## First Session-House of Delegates

M.D.; W. K. Lane, M.D.; Charles A. Lanford, M.D.; Bob G. Lanier, M.D.; Willis E. Lanier, M.D.; J. Moultrie Lee, M.D.; Werner Linz, M.D.

J. Robert Logan, M.D.; William D. Logan, Jr., M.D.; Gary Lodge, M.D.; Gary R. Loveless, M.D.; Larry Lykins, M.D.; Joe B. Massey, M.D.; Richard C. Mattison, M.D.; William E. May, M.D.; Alva Louie Mayes, Jr., M.D.; Joy A. Maxey, M.D.; J. Daniel McAvoy, M.D.; William M. McClatchey, M.D.; Charles W. McDowell, Jr., M.D.; Virgle W. McEver, Jr., M.D.; Ray L. McKinney, M.D.; Jack F. Menendez, M.D.; Margaret Mermin, M.D.; Arthur J. Merrill, Jr., M.D.; Edmund M. Molnar, M.D.; Martin J. Moran, M.D.; Rene A. Morell, M.D.; Toby S. Morgan, M.D.; Joseph V. Morrison, Jr., M.D.; Gerald B. Muller, M.D.; Ellis H. Nelson, M.D.; Joe L. Nettles, M.D.; Bruce C. Newsom, M.D.; John S. Newton, M.D.; Jeffrey T. Nugent, M.D.; Carol

H. Oster, M.D.; E. Capers Palmer, Jr., M.D.; Robert M. Patton, M.D.; Dolford F. Payne, Jr., M.D.; Garland D. Perdue, Jr., M.D.; Richard P. J. Pierzchajlo, M.D.; B. Lamar Pilcher, M.D.; Alan Plummer, M.D.; Harry Porter, Jr., M.D.; James W. Price, M.D.; Willard E. Quillian, III, M.D.; J. L. Rabb, M.D.; Jack A. Raines, M.D.; William J. Rawls, M.D.; James Leon Ray, M.D.; Walker L. Ray, M.D.; Stanley P. Riepe, M.D.; Wells Riley, M.D.; John E. Roberts, Jr., M.D.; Michael H. Roberts, M.D.; Harrison L. Rogers, Jr., M.D.; Clyde B. Rountree, M.D.; Gerald E. Sanders, M.D.; J. K. Schellack, M.D.; Nathan Se-gall, M.D.; Eloise B. Sherman, M.D.; James M. Skinner, M.D.; Edward H. Smith, Jr., M.D.; Henry Briggs Smith, M.D.; Rodney L. Smith, M.D.; Tyson D. Smith, Jr., M.D.; William B. Spearman, M.D.; Charles C. Stamey, M.D.; Cassius M. Stanley, III, M.D.; Dan B. Stephens, M.D.; Joe

C. Stubbs, M.D.; O. Wytch Stubbs, Jr., M.D.; James H. Sullivan, M.D.; Louis W. Sullian, M.D.; Roland S. Summers, M.D.; John P. Syribey, M.D.; David D. Tanner, M.D.; Earle M. Taylor, M.D.; H. Wayne Templeton, M.D.; Luther M. Thomas, Jr., M.D.; Hugh S. Thompson, Jr., M.D.; William C. Tippins, M.D.; James H. Tison, M.D.; Charles E. Todd, Jr., M.D.; Fred A. Trest, M.D.; Charles R. Underwood, M.D.; Karl Ullman, M.D.; Roy W. Vandiver, M.D.; Edward Jones Waits, M.D.; Lamar H. Waters, M.D.; William C. Waters, III, M.D.; John D. Watson, Jr., M.D.; Alexander H. S. Weaver, M.D.; Robert E. Wells, M.D.; William Weston, III, M.D.; William H. Whaley, M.D.; James Q. Whitaker, M.D.; Paul A. Whitlock, Jr., M.D.; Frank L. Wilson, Jr., M.D.; J. S. Wilson, M.D.; Trevor Woodhams, M.D.; Betty B. Wray, M.D.; Charles H. Wray, M.D.; Michael Zoller, M.D.



*There were 137 delegates representing 42 component county medical societies present at the 134th House of Delegates meeting.*



## Alternate Delegate Attendance

William P. Brooks, M.D.; Mark D. Durden, III, M.D.; Douglas J. Erickson, M.D.; Garnett J. Giesler, Jr., M.D.; J. Ray Grant, M.D.; S. T. Hartley, M.D.; Charlie Humphries, Jr., M.D.; Benjamin M. Johnston, M.D.; John N. McClure, Jr., M.D.; A. D. Muse, Jr., M.D.; William C. Pfister, M.D.; David P. Rouben, M.D.; H. W. Smith, M.D.; Thomas Andrew Wade, Jr., M.D.

## Appointments of Reference Committees

The Speaker announced the appointments of the House of Delegates Reference Committees as follows:

### Reference Committee A

Luther M. Thomas Jr., M.D., Chairman, Richmond; Carl V. Hancock, Jr., M.D., Vice Chairman, Dougherty; Phillip N. Bannister, M.D., Gwinnett-Forsyth; Rene A. Morell, M.D., Cobb; Dent W. Purcell, M.D., Georgia Medical Society; William H. Whaley, M.D., Medical Association of Atlanta; Kenneth L. Goldman, M.D., Muscogee; Charles A. Lanford, M.D., Bibb; and David D. Tanner, M.D., Medical Association of Atlanta.

### Reference Committee B

Alexander H. S. Weaver, M.D., Chairman, Bibb; Donald H. Campbell, M.D., Vice Chairman, Cobb; Joseph V. Morrison, Jr., M.D., Georgia Medical Society; J. Patrick Evans, M.D., Georgia Medical Society; Hugh S. Thompson, M.D., Medical Association of Atlanta; Albert A. Carr, M.D., Richmond; Larry Brightwell, M.D., Muscogee; Clinton E. Branch, Jr., M.D., Hall; H. Gordon Davis, Jr., M.D., Worth; and Stefan Fromm, M.D., Whitfield-Murray.

### Reference Committee C

Teresa E. Clark, M.D., Chairman, Medical Association of Atlanta; Edmund M. Molnar, M.D., Vice Chairman, Muscogee; Cassius M. Stanley, III, M.D., Bibb; Charles W. McDowell, Jr., M.D., DeKalb; Wil-

liam Weston, III, M.D., Richmond; Joy A. Maxey, M.D., DeKalb; James F. Beattie, Jr., M.D., Walker-Catoosa-Dade; John S. Newton, M.D., Colquitt; and Gerald E. Sanders, M.D., Cobb.

### Reference Committee D

Ellis B. Keener, M.D., Chairman, Hall; Roland S. Summers, M.D., Vice Chairman, Georgia Medical Society; John E. Roberts, Jr., M.D., Cobb; John A. Hudson, M.D., Bibb; Alan C. Plummer, M.D., Medical Association of Atlanta; William A. Wolff, M.D., Muscogee; Robert D. Gongaware, M.D., Georgia Medical Society; Michael H. Roberts, M.D.; Dougherty; and A. Bleakly Chandler, M.D., Richmond.

### Reference Committee F

H. Duane Blair, M.D., Chairman, DeKalb; Marvyn D. Cohen, M.D., Vice Chairman, Muscogee; Alva L. Mayes, Jr., M.D., Bibb; Bob G. Lanier, M.D., Medical Association of Atlanta; Dan B. Stephens, M.D., Cobb; Billy D. Burk, M.D., Floyd-Polk-Chattooga; and William R. Hardcastle, M.D., DeKalb.

### Reference Committee C & B

James Q. Whitaker, M.D., Chairman, Peachbelt; E. Van Herrin, M.D., Vice Chairman, Crawford W. Long; Clyde B. Roundtree, M.D., DeKalb; Frank E. Carlton, M.D., Georgia Medical Society; Chappell A. Collins, Jr., M.D., Dougherty; Sidney A. Bell, M.D., Floyd-Polk-Chattooga; Thomas Anderson, M.D., Medical Association of Atlanta; and Gary R. Loveless, M.D., Ogeechee River.

### Parliamentarians

Charles A. Lanford, M.D., Bibb; and Richard W. Cohen, M.D., Cobb.

### Teller Committee

J. K. Schellack, M.D., Chairman, Medical Association of Atlanta; Donald C. Abele, M.D., Richmond; William H. Whaley, M.D., Medical Association of Atlanta; Charles W. McDowell, Jr., M.D., DeKalb; and Eloise B. Sherman, M.D., Georgia Medical Society.

## Credentials Committee

Milton I. Johnson, Jr., M.D., Chairman, Bibb.

## Adoption of Minutes

The Proceedings of the 1987 meeting of the MAG House of Delegates as published in the June, 1987, *Journal of the Medical Association of Georgia*, were approved.

## Nominations

Speaker Kaufmann called on the House to proceed with nominations for the Officers, AMA Delegates, AMA Alternate Delegates, and MAG Delegate and Alternate Delegate to the AMA Young Physicians Section.

## Election of Unopposed Candidates

It was agreed at the outset that unopposed candidates would be elected at this Session and the names of the candidates who have opposition would appear on the ballot for election, Saturday, April 30, 1988. Upon nominations duly made and seconded as indicated below, the following slate of unopposed officers were elected by acclamation:

*President-Elect:* Joe L. Nettles, M.D., Savannah, was nominated by Joseph V. Morrison, Jr., Savannah, and seconded by Luther Thomas, M.D., Augusta.

*Second Vice President:* Bob G. Lanier, M.D., Atlanta was nominated by Hugh Thompson, M.D., Atlanta, and seconded by Joe L. Nettles, M.D., Savannah.

*Elections of AMA Delegates and Alternate Delegates:* Due to the resignation of AMA Alternate Delegates, L. Newton Turk, III, M.D., Atlanta, and C. Peter Lampros, M.D., Toccoa, Dr. Kaufmann asked the consent of the House that the unexpired terms of office be included in the election to the full term for the alternate delegates.

*AMA Delegate:* Carson B. Burgstiner, M.D., Savannah, was nominated to succeed himself by Har-



# First Session-House of Delegates

risson Rogers, M.D., Atlanta, and seconded by William D. Logan, Jr., M.D., Atlanta.

*AMA Delegate:* S. William Clark, Jr., M.D., Waycross, was nominated to succeed himself by Gordon Davis, M.D., Sylvester, and seconded by Joseph M. Jackson, M.D., Folkston.

*AMA Delegate:* Joe C. Stubbs, M.D., Valdosta, was nominated to succeed himself by Louis Felder, M.D., Atlanta, and seconded by E. M. ("Mac") Molnar, M.D., Columbus.

*AMA Alternate Delegate:* E. M. ("Mac") Molnar, M.D., Columbus, was nominated to succeed himself by Ken L. Goldman, M.D., Columbus, and seconded by Joe C. Stubbs, M.D., Valdosta.

*AMA Alternate Delegate:* Beverly B. Sanders, M.D., Macon, was nominated to succeed himself by Milton I. Johnson, M.D., Macon, and seconded by Joseph P. Bailey, Jr., M.D., Augusta.

*AMA Alternate Delegate:* Ellis B. Keener, M.D., Gainesville, was nominated to succeed himself by Robert H. Anderson, Jr., Gainesville, and seconded by William D. Logan, Jr., Atlanta.

*AMA Alternate Delegate:* Jack F. Menendez, M.D., Macon, was nominated to fill the unexpired term of L. Newton Turk, III, Atlanta, by Cash Stanley, M.D., Macon, and seconded by Alva L. Mayes, Jr., M.D., Macon.

*AMA Alternate Delegate:* Richard W. Cohen, M.D., Austell, was nominated to fill the unexpired term of C. Peter Lampros, M.D., Toccoa, by Walter Ligon, M.D., Marietta, and seconded by Louis Felder, M.D., Atlanta.

*MAG Delegate to AMA Young Physicians Section:* Spurgeon Wm. Clark, III, M.D., Waycross, was nominated by James Beattie, M.D., Fort Oglethorpe, and seconded by Ralph A. Tillman, M.D., Lawrenceville.

*MAG Alternate Delegate to AMA Young Physicians Section:* Joy A. Maxey, M.D., Atlanta, was nomi-

nated by James Beattie, M.D., Fort Oglethorpe, and seconded by Don Campbell, M.D., Marietta.

*Judicial Council:* Robert B. Cope-land, M.D., LaGrange, was nominated by Jack F. Menendez, M.D., Macon, for a term to expire in 1993.

## Directors and Alternate Directors

Speaker Kaufmann announced the results of elections for Directors and Alternate Directors as conducted by the District Medical Societies and Component County Medical Societies:

### First District

Leon Curry — Director

Gary Loveless — Alternate Director

### Second District

W. Charles Pfister — Director

C. Gary Lodge — Alternate Director

### Third District

Virgle W. McEver, Jr. — Director

James Q. Whitaker — Alternate Director

### Sixth District

Werner A. Linz — Director

J. R. Turner — Alternate Director

### Seventh District

Bannester L. Harbin — Director

J. R. Turner — Alternate Director

### Tenth District

William M. Headley — Director

Charles E. Wills — Alternate Director

### Bibb County Medical Society

Charles A. Lanford — Director

Alva L. Mayes, Jr. — Alternate Director

### Crawford W. Long Medical Society

Van Herrin — Director

David C. Allen — Alternate Director

### Dougherty County Medical Society

Carl V. Hancock — Director

A. Frank Isele — Alternate Director

### Hall County Medical Society

John H. Reed — Director

James Leigh, Jr. — Alternate Director

## Medical Association of Atlanta

J. Harold Harrison — Director

William Waters, III — Alternate Director

## Georgia Medical Society

J. Patrick ("Pat") Evans — Director

Roland S. Summers — Alternate Director

## Reports of Officers

President — Rec. 1 — Ref. Comm. D; Rec. 2 (a, b) — Ref. Comm. D; Rec. 2 (a, b) — Ref. Comm. C; Rec. 2 (c, d) — Ref. Comm. C; Rec. 3, 4, 5 — Ref. Comm. D; Rec. 6 — Ref. Comm. A; Rec. 7 — Ref. Comm. C.

Immediate Past President — not referred.

First Vice President — Rec. 1 — Ref. Comm. C; Rec. 2 — Ref. Comm. D; Rec. 3 — Ref. Comm. A.

Second Vice President — Ref. Comm. D.

Second Vice President (Supplemental) — Ref. Comm. D.

Secretary — Ref. Comm. A.

Treasurer — Ref. Comm. F.

Speaker — Ref. Comm. A.

Vice Chairman of the Board — Ref. Comm. A.

## Reports of Directors

The following Directors' reports were not referred to a Reference Committee:

First District Medical Society

Second District Medical Society

Third District Medical Society

DeKalb Medical Society

Medical Association of Atlanta

Sixth District Medical Society

Seventh District Medical Society

Eighth District Medical Society

Ninth District Medical Society

Tenth District Medical Society

Bibb County Medical Society

Clayton-Fayette County Medical Society

Cobb County Medical Society

Crawford W. Long Medical Society

Dougherty County Medical Society

Floyd-Polk-Chattooga County Medical Society

Georgia Medical Society



Hall County Medical Society  
Muscogee County Medical Soci-

ety  
Richmond County Medical Soci-  
ety

## Reports of Departments

*Journal of the Medical Association of Georgia* — not referred.

## Special Reports

Hospital Medical Staff Section —  
Ref. Comm. D.

MAG Mutual — Ref. Comm. A.

Substitute MAG Mutual Report  
with Supplemental Attachment  
(Substitute) — Ref. Comm. A.

AMA Delegation — not referred.

Georgia Health Network — not  
referred.

Judicial Council — not referred.

Auxiliary — not referred.

Resident Physician Section — not  
referred.

Medical Student Section — not  
referred.

## Committee Reports

Access to Medical Care — Ref.  
Comm. D.

Auxiliary — not referred.

Building & Land — not referred.

Cancer — not referred.

Computers in Medicine — Ref.  
Comm. A.

Constitution & Bylaws — Ref.  
Comm. C & B.

Constitution & Bylaws — Ref.  
Comm. C & B.

Constitution & Bylaws — Ref.  
Comm. C & B.

Continuing Medical Education —  
Ref. Comm. D.

Cost Awareness — Ref. Comm.  
B.

Emergency Medical Services —  
Ref. Comm. B.

Legislative Council — Ref.  
Comm. C.

Maternal & Infant Health — not  
referred.

Medical Aspects of Sports — not  
referred.

Medical Practice — Ref. Comm.  
B.



(L-R) Drs. Roy Vandiver, Bill Tippins, and Bill Keeton.

Medical Schools — Ref. Comm.  
D.

Medicine & Human Values — not  
referred.

Membership — Ref. Comm. A.

Non-Physician Health Care Pro-  
viders — Ref. Comm. A.

Physician-Lawyer Liaison — Ref.  
Comm. C.

Prison Health Care — not re-  
ferred.

Public Health — Rec. 1 — Ref.  
Comm. C. Rec. 2 — Ref. Comm. A.

Public Relations — Rec. 1 — Ref.  
Comm. A. Rec. 2 — Ref. Comm. F.

Scientific Assembly — not re-  
ferred.

Specialty Society Relations — not  
referred.

Third Party Payors — Rec. 1, 2,  
3 — Ref. Comm. B. Rec. 4 — Ref.  
Comm. C.

Trustee Advisory — not referred.

Ad Hoc on AIDS — Ref. Comm.  
A.

Ad Hoc on Alternatives to Tort  
Reform — Ref. Comm. C.

Ad Hoc on Alternative Solutions  
to the Nursing Care Crisis — not  
referred.

Substitute Committee Report of  
the Ad Hoc on Diversion of Legiti-  
mate Prescription Drugs — Ref.  
Comm. C.

Liaison with Georgia Osteopathic  
Medical Association — not re-  
ferred.

Ad Hoc on Impaired Physicians  
Oversight — not referred.

Ad Hoc MAG IPA/HMO Study —  
not referred.

Ad Hoc on Medical Care for the  
Disadvantaged — Rec. 1, 3 — Ref.  
Comm. A. Rec. 2 — Ref. Comm. C.

Ad Hoc on Physicians Dispens-  
ing and Drugs Rec. 1, 2 — Ref.  
Comm. D. Rec. 3, 4 — Ref. Comm.  
C.

Ad Hoc on Primary Care — Ref.  
Comm. B.

Ad Hoc on PRO Review — Ref.  
Comm. B.

Ad Hoc on Professional Liability  
Support Groups — not referred.

Ad Hoc on Radiology Technol-  
ogists — not referred.

Ad Hoc for Tort Reform — Ref.  
Comm. C.

Ad Hoc on Young Physicians  
Section — not referred.



# First Session-House of Delegates

## Resolutions

Number of Directors: Bylaws Amendment — Res: 1, C & B.

Membership of Osteopaths in MAG — Res: 2, C & B.

MAG Medical Student Section Voting Delegate — Res: 3, C & B.

C&B Amendments — 45 Day Prior Receipt — Res: 4, C & B.

Diversion of Legitimate Schedule II Narcotic Drugs/Multi-copy Prescription Bill — Res: 5, C.

Regulation of Managed Care Agencies — Res: 6, B.

Guide to Contracting — Res: 7, B.

Medical Association of Georgia's Involvement in the Adolescent Urine Drug Screening Program — Res: 8, A.

Georgia Health Network Assessment — Res: 9, B.

GHN Stock — Res: 10, B.

Georgia IPA — Res: 11, B.

MAG Dues — Res: 12, F.

GHN — Res: 13, B.

Alternative Income Study — Res: 14, F.

Alcohol Awareness Information — Res: 15, A.

Military Interception of Illegal Drugs — Res: 16, C.

Admission of Doctors of Osteopathy to MAG — Res: 17, C & B.

Medicare Reimbursement Caps — Res: 18, C.

Onerous Policies of Procedures from Third Party Payors — Res: 19, B.

Control of Handguns — Res: 20, C.

Encroachment of Third Party Payors Inquiries on Physician Control of Patient Care — Res: 21, B.

MAG Legislation — Res: 22, C.

Funding for Grady Memorial Hospital — Res: 23, C.

Treatment Guidelines for Terminal Patients — Res: 24, B.

Insurance for Well Child Supervision — Res: 25, C.

Medicare — Res: 26, B.

Fiscal Impact of Third Party Payors' Administrative Regulations — Res: 27, B.

Preservation of Animal Resources for Biomedical Research — Res: 28, C.

Specialty Journals — Res: 29, D.

Continuing Medical Education — Res: 30, D.

Treatment of AIDS Patients — Res: 31, A.

Licensure of Foreign Medical Graduates — Res: 32, D.

Medico-Legal Death Investigation in Georgia — Res: 33, C.

Investigation of Medical Aspects of Death — Res: 34, C.

Public Information Re: Medicare — Res: 35, B.

Medical School Deans as Delegates — Res: 36, D.

Peer Review Contract with Board of Medical Examiners — Res: 37, C.

Medicaid Reimbursement to Children's Hospitals and Related Institutions — Res: 37, B.

Medicare — Res: 39, B.



(L-R) Drs. Virgle McEver, Bob Logan, and Roland Summers.



# An outline of Georgia's *newest* physical rehabilitation center

## I. Palmyra Regional Rehabilitation Center

- A. Comprehensive rehabilitation
  - 1. Major physical and/or cognitive disabilities
  - 2. Inpatient *and* outpatient services
- B. Acute care hospital setting
  - 1. Modern 48-bed facility
  - 2. Located adjacent to HCA Palmyra Medical Centers
- C. Southwest Georgia's only inpatient rehabilitation facility

## II. Diagnoses treated

- A. Stroke and neurological diseases
- B. Spinal cord injury
- C. Head injury
- D. Arthritis
- E. Pediatric neuromuscular diseases
- F. Amputee
- G. Burns

## III. Services available

- A. Rehabilitative nursing
- B. Rehabilitative therapy
  - 1. Physical therapy
  - 2. Occupational therapy
  - 3. Speech and language pathology
  - 4. Therapeutic recreation
- C. Psychology
- D. Social work
- E. Vocational counseling
- F. Prosthetics and orthotics

## IV. Special procedures

- A. Nerve conduction studies
- B. Electromyography
- C. Evoked potentials

## V. Medical Director

- A. Board certified physiatrist
- B. Oversees medical and physical rehabilitation of all patients
- C. On campus office

## VI. Multidisciplinary team approach

- A. Individualized treatment plans
- B. Weekly team conferences
- C. Outside consults as needed



 **Palmyra Regional  
Rehabilitation Center**

**2000 Palmyra Road  
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For information, call toll free in Georgia:

**1-800-422-1189**

In the Albany area or outside Georgia call:

**(912) 434-8660**



# Unreferred Reports



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## REPORT OF THE IMMEDIATE PAST PRESIDENT

**John D. Watson, Jr., M.D.,  
Immediate Past President**

**T**he continual challenges of society frequently bring out the best in organization and leadership. And again, your leadership under the firm hand of President Menendez, has displayed amazing abilities and agility in dealing with an absolute myriad of problems and challenges.

On the fun side was the Interim meeting of the AMA in Atlanta which was a smashing success. The extensive study and policy decisions on the AIDS' issue was accomplished in the finest professional manner. The extensive reorganization of our legislative team and the unbelievable number of challenges thrust upon this team and the whole organization would make this a landmark year by any measure.

Once again, the success of the Medical Association of Georgia does not occur by accident. It does

occur by the dedicated contributions of your officers and the ever present and loyal staff. So much has happened, so many are to be applauded, I dare not to begin to mention names. From our marvelous supporting Auxiliary and its President, Maureen Vandiver, to the many committees, the many unsung participants in so many efforts who are not properly recognized both in the professional and staff sides, and our most excellent *Journal*, let me applaud you. Let me say that I know why the Medical Association of Georgia continues to be one of the best State Associations in the nation. Why we are looked up to for leadership throughout the Federation. It has been my pleasure and privilege to serve with this most excellent group, and I thank you. Now, let us continue our good works with that same dedication and zeal.





*Not all the proceedings of the House were serious. Spontaneous humor added welcome variety.*

## FIRST DISTRICT MEDICAL SOCIETY

Leon E. Curry, M.D., Director

Counties and Secretaries	Members 12/31/86		Members 12/31/87	
	MAG	AMA*	MAG	AMA*
Ogeechee River Emory Smith Statesboro	38	31	38	31
Burke Joseph L. Jackson Waynesboro	6	4	7	4
Emanuel T. M. Tamblyn, III Swainsboro	5	3	6	3
Laurens Diane Davis Dublin	47	26	48	26
Screven William R. Kent Sylvania	5	3	1	0
Southeast Georgia Benjamin Barnard Vidalia	21	3	22	4
St. Johns Parish Grace C. Bautista Hinesville	8	1	10	2
	<u>130</u>	<u>71</u>	<u>132</u>	<u>70</u>

\* Members paying AMA dues via MAG





Vice Speaker of the House, Jack A. Raines, M.D., of Columbus.

## SECOND DISTRICT MEDICAL SOCIETY

Sammie Dixon, M.D., Director

Counties and Secretaries	Members 12/31/86		Members 12/31/87	
	MAG	AMA*	MAG	AMA*
Colquitt Norman Reese Moultrie	30	15	30	15
Decatur-Seminole K. Dean Burke Bainbridge	17	10	15	11
Mitchell A. A. McNeill, Jr. Camilla	4	2	5	3
Southwest Georgia Virendra M. Saxena Fort Gaines	10	3	12	4
Thomas Area W. A. Lardin Thomasville	60	38	60	38
Tift Indra C. Shah Tifton	44	24	51	27
Worth H. G. Davis, Jr. Sylvester	4	3	4	3
	<u>169</u>	<u>95</u>	<u>177</u>	<u>101</u>

\* Members paying AMA dues via MAG

## THIRD DISTRICT MEDICAL SOCIETY

V. W. McEver, Jr., M.D., Director

Counties and Secretaries	Members 12/31/86		Members 12/31/87	
	MAG	AMA*	MAG	AMA*
Flint John B. Adams, Jr. Cordele	11	6	13	4
Peachbelt Manoj H. Shah Warner Robins	54	38	51	36
Randolph-Stewart-Terrell Emilio Delgado Dawson	5	1	3	1
Sumter William R. Anderson Americus	31	16	25	13
	<u>101</u>	<u>61</u>	<u>92</u>	<u>54</u>

\* Members paying AMA dues via MAG



## DEKALB MEDICAL SOCIETY

Charles McDowell, Jr., M.D., Director

County and Secretary	Members 12/31/86		Members 12/31/87	
	MAG	AMA*	MAG	AMA*
DeKalb Gary Botstein Decatur	345	191	320	184

\* Members paying AMA dues via MAG

## MEDICAL ASSOCIATION OF GEORGIA

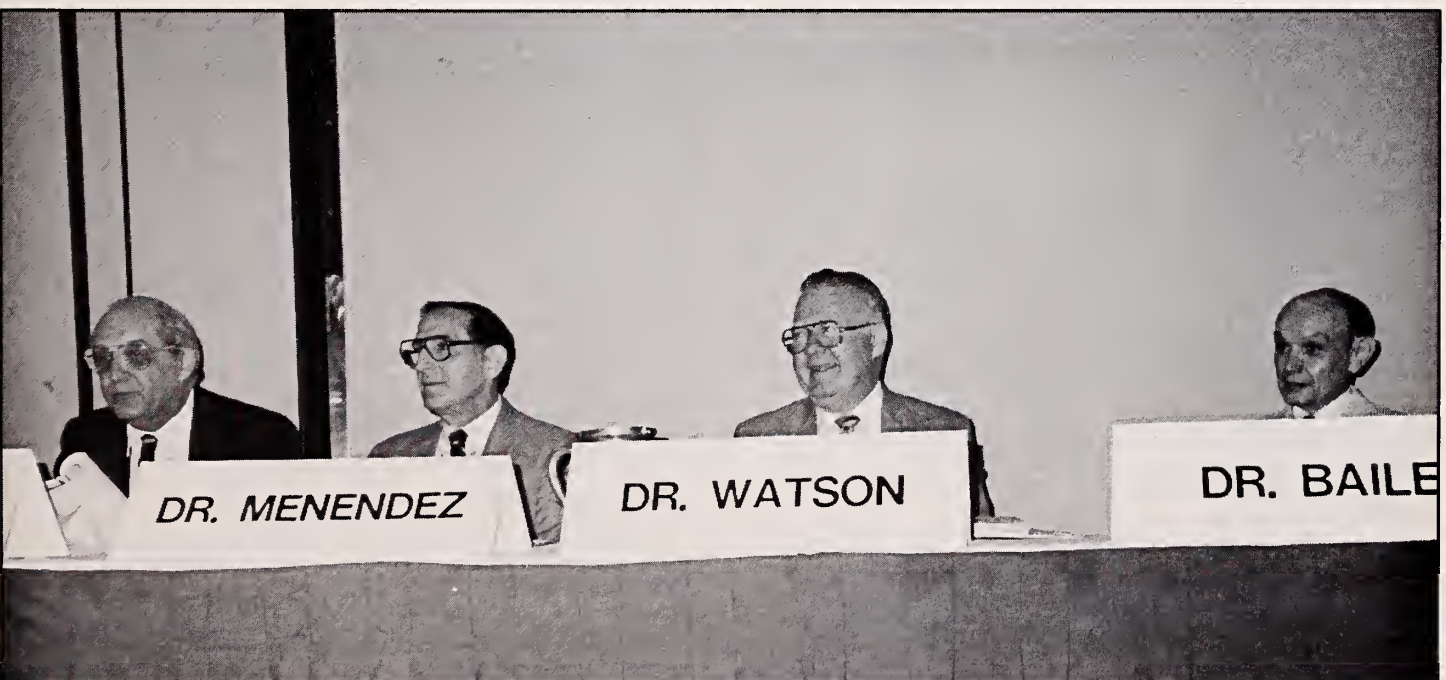
William C. Collins, M.D., Director

T. J. Anderson, Jr., M.D., Director

J. Harold Harrison, M.D., Director

County and Secretary	Members 12/31/86		Members 12/31/87	
	MAG	AMA*	MAG	AMA*
M.A.A. Teresa Clark Atlanta	1702	897	1888	989

\* Members paying AMA dues via MAG



*A portion of the head table of the House.*



## SIXTH DISTRICT MEDICAL SOCIETY

Werner A. Linz, M.D., Director

Counties and Secretaries	Members 12/31/86		Members 12/31/87	
	MAG	AMA*	MAG	AMA*
Coweta Joe W. Parks, III Newnan	37	20	31	19
Henry (no officers)	10	4	5	3
Meriwether-Harris-Talbot James Knowles Warm Springs	7	3	9	4
Spalding Kenneth R. Lindyberg Griffin	48	25	52	22
Troup J. Connor Smith LaGrange	62	48	58	47
Upton Dan J. Bramlett Thomaston	26	9	26	9
	<u>190</u>	<u>109</u>	<u>181</u>	<u>94</u>

\* Members paying AMA dues via MAG

## SEVENTH DISTRICT MEDICAL SOCIETY

B. L. Harbin, Jr., M.D., Director

Counties and Secretaries	Members 12/31/86		Members 12/31/87	
	MAG	AMA*	MAG	AMA*
Bartow John T. Perry Cartersville	6	3	12	7
Carroll-Haralson Frederick Martin Carrollton	41	26	44	25
Gordon Richard Gusso Calhoun	22	7	21	8
Douglas Veeni S. Kumar Douglasville	20	12	23	10
Walker-Catoosa-Dade Bruce A. Elrod Ft. Oglethorpe	46	28	44	2
Whitfield-Murray Robert A. Burns Dalton	80	65	79	66
	<u>215</u>	<u>141</u>	<u>223</u>	<u>118</u>

\* Members paying AMA dues via MAG





*Another portion of the head table.*

## EIGHTH DISTRICT MEDICAL SOCIETY

Joe C. Stubbs, M.D., Director

Counties and Secretaries	Members 12/31/86		Members 12/31/87	
	MAG	AMA*	MAG	AMA*
Altamaha B. S. Patel	8	2	8	3
Baxley Ben Hill-Irwin William J. Hammond Fitzgerald	7	7	8	8
Coffee A.V.S. Sarma Douglas	11	8	12	5
Camden-Charlton Frank Scarvey, III St. Mary's	13	3	16	5
Glynn Turner W. Rentz Brunswick	76	38	77	41
Ocmulgee Emil B. Georgi Eastman	20	16	20	12
South Georgia Donald J. Mirate Valdosta	82	41	90	38
Ware S. William Clark, III Waycross	58	36	54	29
Wayne Ollie O. McGahee Jesup	15	4	12	2
	290	155	297	143

\* Members paying AMA dues via MAG



## NINTH DISTRICT MEDICAL SOCIETY

Rupert H. Bramblett, M.D., Director

Counties and Secretaries	Members 12/31/86		Members 12/31/87	
	MAG	AMA*	MAG	AMA*
Barrow	11	2	11	3
William T. MacNew, Jr.				
Winder				
Blue Ridge	7	4	11	4
Robert A. Burns				
Blue Ridge				
Elbert	7	3	9	6
Zeb L. Burrell				
Elberton				
Gwinett-Forsyth	79	31	96	46
Rupert H. Bramblett				
Cumming				
Cherokee-Pickens	22	14	21	10
Gerald J. Hobson (Pres.)				
Canton				
Habersham	9	7	11	6
James C. Harmon				
Cornelia				
Hart	5	3	5	1
L. G. Cacchioli (Pres.)				
Hartwell				
Jackson-Banks	8	6	9	6
Susan Alexander				
Commerce				
Lumpkin	7	3	9	5
David Causey				
Dahlonega				
Stephens-Rabun	33	8	32	8
John V. Glisson				
Toccoa				
	188	81	214	95

\* Members paying AMA dues via MAG



## TENTH DISTRICT MEDICAL SOCIETY

William M. Headley, M.D., Director

Counties and Secretaries	Members 12/31/86		Members 12/31/87	
	MAG	AMA*	MAG	AMA*
Baldwin Pedro Tamayo Milledgeville	59	24	51	24
Franklin Hoyt Crump Royston	5	4	5	4
Jefferson (no officers)	3	1	3	0
McDuffie Michael Powell (Pres.) Thomson	3	3	3	3
Newton-Rockdale Millard I. Ross Conyers	48	20	45	20
Oconee Valley Rakesh Kumar Eatonton	13	5	12	3
Walton Jeff Cohenour Monroe	15	8	20	12
Washington W. M. Rawlings, Jr., (Pres.) Sandersville	8	1	6	1
Wilkes C. W. Pollock Washington	5	4	5	4
	159	70	150	71

\* Members paying AMA dues via MAG

## BIBB COUNTY MEDICAL SOCIETY

Charles A. Lanford, M.D., Director

County and Secretary	Members 12/31/86		Members 12/31/87	
	MAG	AMA*	MAG	AMA*
Bibb Ronald A. Freeman Macon	344	206	354	233

\* Members paying AMA dues via MAG





*Dr. James A. Kaufmann, of Atlanta,  
Speaker of the House.*

## CLAYTON-FAYETTE COUNTY MEDICAL SOCIETY

**Selwyn T. Hartley, M.D., Director**

County and Secretary	Members 12/31/86		Members 12/31/87	
	MAG	AMA*	MAG	AMA*
Clayton-Fayette Rayasam Prasad Riverdale	115	56	124	51

\* Members paying AMA dues via MAG

## COBB COUNTY MEDICAL SOCIETY

**Dan B. Stephens, M.D., Director**

County and Secretary	Members 12/31/86		Members 12/31/87	
	MAG	AMA*	MAG	AMA*
Cobb Rene A. Morell Austell	334	203	355	200

\* Members paying AMA dues via MAG

## CRAWFORD W. LONG MEDICAL SOCIETY

**Philip A. Sheffield, M.D., Director**

County and Secretary	Members 12/31/86		Members 12/31/87	
	MAG	AMA*	MAG	AMA*
Crawford W. Long James E. Dempsey Athens	113	75	106	77

\* Members paying AMA dues via MAG



## DOUGHERTY COUNTY MEDICAL SOCIETY

Frank F. Middleton, III, M.D., Director

County and Secretary	Members 12/31/86		Members 12/31/87	
	MAG	AMA*	MAG	AMA*
Dougherty Atwood M. Freeman, Jr. Albany	136	93	151	102

\* Members paying AMA dues via MAG

## FLOYD-POLK-CHATTOOGA COUNTY MEDICAL SOCIETY

Joel Todino, M.D., Director

County and Secretary	Members 12/31/86		Members 12/31/87	
	MAG	AMA*	MAG	AMA*
Floyd-Polk-Chattooga John T. Collins Rome	141	76	149	71

\* Members paying AMA dues via MAG

## GEORGIA MEDICAL SOCIETY

J. Patrick Evans, M.D., Director

County and Secretary	Members 12/31/86		Members 12/31/87	
	MAG	AMA*	MAG	AMA*
Georgia Medical Society Lawrence E. Ruf Savannah	276	182	290	193

\* Members paying AMA dues via MAG

## HALL COUNTY MEDICAL SOCIETY

John Reed, M.D., Director

County and Secretary	Members 12/31/86		Members 12/31/87	
	MAG	AMA*	MAG	AMA*
Hall W. Jackson Thompson Gainesville	125	91	133	88

\* Members paying AMA dues via MAG



Among those shown here are M. Julian Duttera, M.D., of LaGrange, a member of the Journal's Editorial Board; and William C. Collins, M.D. of Atlanta, Chairman of MAG's Board of Directors.



## MUSCOGEE COUNTY MEDICAL SOCIETY

E. M. Molnar, M.D., Director

County and Secretary	Members 12/31/86		Members 12/31/87	
	MAG	AMA*	MAG	AMA*
Muscogee William H. Hayes Columbus	258	156	266	151

\* Members paying AMA dues via MAG

## RICHMOND COUNTY MEDICAL SOCIETY

Luther M. Thomas, M.D., Director

James L. O'Quinn, M.D., Director

County and Secretary	Members 12/31/86		Members 12/31/87	
	MAG	AMA*	MAG	AMA*
Richmond A. Bleakley Chandler Augusta	541	280	575	285

\* Members paying AMA dues via MAG

## JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

Charles R. Underwood,  
M.D., Editor

**Y**our *Journal* continues healthy. We are at present blessed with a surfeit of articles which have been submitted to us, reviewed, and accepted for publication. While trying to accurately interpret the position of the *Journal* as a medium for publication of scientific articles by the membership, your Editorial Board has nonetheless made a conscious effort to carefully and critically evaluate this material submitted for publication with a view toward constantly upgrading the quality of these scientific articles. We also

view the publication as a means of bringing to the attention of the members of the Association matters other than scientific — particularly in the area of financial and sociological material.

We continue to strive toward keeping the *Journal* fiscally sound. Our income derives from two main sources, namely paid advertising and a certain portion of membership dues designated as a "subscription cost" for the monthly receipt of the *Journal*. A small amount of additional income is received from subscriptions to individuals not members of the M.A.G. The past year has seen a slackening of income from paid advertising, a matter which is of concern to your Editor and which is at the present time being aggressively pursued in an effort to maximize this particular source of income. From a fiscal standpoint, the *Journal* strives to ar-

rive at a "break-even point" and must not in our view be considered as an income producing vehicle for the Association.

The Editorial Board remains intact and functioning smoothly. We keep in close touch with each other and make an attempt to gather for a meeting to discuss the functioning of the *Journal* as often as practical.

It is the hope of your Editor, Managing Editor, and all members of the Editorial Board that you the membership find the *Journal* to be helpful and interesting. We are constantly looking for new avenues by which we might accomplish these ends. We appreciate your plaudits but are even more in need of your honest and carefully considered criticism and to that end would appreciate hearing from anyone who might feel that they have suggestions by which we might improve your *Journal*.

## AMA DELEGATION

C. Emory Boher, M.D.

### Introduction

**T**he AMA House of Delegates met in Atlanta, December 6-9, 1987 with 411 delegates seated including the following five new specialty societies that were admitted to this meeting:

- American Rheumatism Association
- American Association of Electromyography and Electrodiagnosis
- American Society for Dermatologic Surgery, Inc.
- American Society of Clinical Oncology
- American Society of Maxillofacial Surgeons

The House composition is:

- 327 delegates representing state medical associations



- 74 delegates representing national medical specialty societies
- 10 Section and Service delegates representing medical students, medical schools, resident physicians, hospital medical staffs, young physicians, Army, Navy, Air Force, USPHS, and the Veterans Administration.

## Address of the President

William S. Hotchkiss, M.D., AMA President, offered a clear message regarding two major challenges facing the profession — maintaining unity in medicine and ensuring professional autonomy in decision-making. He observed that the AMA is working to foster close and congenial working relationships with specialty societies in a concerted effort to help physicians maintain control over patient care. To ensure success in these efforts, Dr. Hotchkiss called for physicians to become personally involved and to stand together without fractional strife.

## Items of Business

The delegates considered 76 reports and 146 resolutions. Problems associated with physician reimbursement under Medicare, PRO regulations, professional liability, and the complex social, ethical, and medical aspects of the AIDS epidemic occupied the delegates' attention. A number of other issues affecting the future of medical practice and medical education were on the agenda.

## The AIDS Epidemic

The House filed an important report of the Council on Ethical and Judicial Affairs providing ethical guidelines to physicians on three significant issues related to the AIDS epidemic:

1. A physician may not ethically refuse to treat a patient solely because the patient is seropositive.

2. Where there is no statute that mandates or prohibits the reporting of seropositive individuals to public health authorities and a physician knows that a seropositive patient is endangering a third party, the physician should:
  - a. attempt to persuade the infected patient to cease;
  - c. if persuasion fails, notify the authorities;
  - c. if the authorities take no action, notify the endangered third party.
3. A physician who knows that he or she has an infectious disease should not engage in any activity that creates a risk of transmission of the disease to others.

## AMA Activities Related to AIDS

The House adopted a Board report that describes a full range of Association activities in response to the growing AIDS crisis, including:

- Publication and distribution of 11 informational reports on AIDS to 370,000 physicians.
- Regional AIDS health education programs were conducted in Pennsylvania, Texas, California, and Illinois.
- A national conference on "AIDS and Public Policy: A Community Response" was held in April with 800 attendees.
- Another national conference planned for March, 1988 and a video clinic on "AIDS in the Workplace" is under development.
- Through the judicial process the AMA has continued to exercise leadership in protecting patients with AIDS from unreasoned discrimination based on their handicap.
- A number of other educational activities were reported including cooperating with the CDC in the development of informational brochures for the public,

public service announcements, and radio programming.

## Problems in AIDS Education

The House approved a report outlining various national efforts in educating the public on the prevention of AIDS. The report claims that efforts in health education and prevention have been inadequate in scope and lack coordination.

The report, submitted by the AMA Council on Scientific Affairs, recommended that the AMA support AIDS education in the United States by:

- Encouraging national coordination and tracking of all major AIDS health education and prevention activities.
- Encouraging the federal government through AMA policy statements and recommendations to increase funding for prevention and education significantly in accordance with Public Health Service Projections of the incidence of HIV-related disease.
- Encouraging the federal government through AMA policy statements and recommendations to take a stronger leadership role in ensuring interagency cooperation, private sector involvement, and the dispensing of funds based upon real and measurable needs.
- Organizing, in collaboration with other groups, a national conference aimed at developing strategies and recommendations for AIDS education in the United States.
- Developing and facilitating by all methods available to the AMA educational resources and effective delivery programs for specific targeted groups.
- Encouraging physicians to assist parents in providing human sexuality education to children and adolescents.



## Professional Liability

Professional liability continues to be of critical importance to medicine, generating much discussion at the Interim Meeting.

The House adopted a comprehensive report prepared by the AMA's Special Task Force on Professional Liability and Insurance and the AMA's Advisory Panel on Professional Liability. The Report:

- described recent federal activity in this area
- described recently developed alternatives to the civil justice system
- discussed risk retention groups, procedural based insurance rating plans, and the availability of Directors and Officers liability insurance.

The House also considered a number of resolutions on this issue and approved:

- a resolution calling upon the AMA to compile a report of state tort reforms that have been overturned by the courts in the past 15 years.
- a resolution calling on the AMA to support and commend the efforts of the Florida Medical Association in seeking enactment of an alternative mechanism to the current tort system for resolving medical liability disputes; called "Medical Incident Compensation Act" (MICA). The resolution also asked the AMA to carefully evaluate MICA along with other tort reform measures.
- a resolution calling on the AMA to seek the cooperation of state medical associations and consumer groups to procure the enactment of legislation that will limit contingent lawyer's fees to a reasonable percentage of the net recovery.

## Physician Reimbursement under Medicare

Numerous reports and resolutions addressed the continuing

problems physicians are having with the administration of the Medicare Program.

They considered a comprehensive informational report providing an update on the current status of the Medicare physician payment issue and detailing the intensive AMA activities in this area.

The House also approved a resolution that calls on the AMA "to reaffirm to the public the principle that payment schedules adopted by third party payors shall be construed as schedules of benefits to their covered insureds except in cases where physicians have voluntarily contracted with the insurer to accept those benefits as payment in full for services rendered, or as required by law."

## Protection for Medicare Patients of Limited Means

A resolution was adopted that asks the AMA to aid and encourage individual state medical societies to develop voluntary Medicare assignment programs which will assist in the protection of the financial resources of the elderly of limited means and which will ensure access to health care for all of the elderly.

The House also recognized the National Eye Care Project of the American Academy of Ophthalmology as an example of other societies to follow.

In a final word on the subject, the House approved a resolution calling on the AMA Board of Trustees to continue to actively oppose, through appropriate political and legal means, any and all actions by any governmental agency or legislative body which would require mandatory acceptance of Medicare assignment and that all concerned physicians be encouraged to join with the AMA in the active opposition to such oppressive action.

## Maximum Allowable Actual Charge (MAAC)

Inequities in Medicare's maxi-

mum allowable actual charge limits stimulated several resolutions and stirred considerable debate among the physicians.

The House approved policy to:

- seek legislation to eliminate unfair fee distortions created by the current MAAC implementations
- exert every effort to prevent physicians from being penalized, persecuted, or prosecuted for unintentional possible MAAC violations
- relieve physicians of the inequitable MAAC provisions
- eliminate the artificial and misleading categorization of physicians as "participating" or "nonparticipating"
- seek to correct MAAC discrimination against young physicians
- oppose efforts by commercial carriers or the federal government which would require physicians to predict reimbursement for services rendered
- work for repeal of the provision of the Omnibus Budget Reconciliation Act of 1986 regarding notification of patients receiving elective surgery of the physician charge and the amount the patient would be expected to pay when the charge is \$500 or more and the claim is not accepted on an assigned basis
- work to repeal provisions that require physicians to refund payments associated with Medicare services that are deemed medically unnecessary by HCFA after the fact
- communicate to the federal government that:
  1. increases in Medicare reimbursement need to be universal
  2. current reimbursement needs to be adjusted
  3. discrimination in schedules between participating and nonparticipating physicians should be ended.



## Peer Review Organizations (PRO's)

The House considered a status report on current PRO program developments and on the activities of the Ad Hoc Committee on PRO. The House learned that significant progress has been made in working with HCFA, as well as Congress, on PRO concerns. The House noted the current willingness of federal PRO program officials to listen to the concerns of physicians.

The House took a number of actions to seek redress of weaknesses in the PRO program, asking the AMA to:

- challenge both the PRO's and HCFA publicly and politically, to develop a program that honestly promotes high quality and the delivery of efficient medical care
- take appropriate steps to assure that the PRO statutes as now written and implemented through HCFA guidelines reflect the community standards for high quality care
- call upon Congress and HCFA to assure sufficient funding for programs to inform patients and physicians concerning the actions of PRO's
- urge that peer review organization review be extended to all care rendered in government-managed hospitals and systems
- work to eliminate the bounty system in the Office of HHS Inspector General which provides employees with bonuses based on the number of sanctions imposed and penalties recovered
- take appropriate steps to assure that physicians have early input in the PRO complaint process and receive appropriate due process review opportunities prior to any report being sent to the patient regarding the quality of care provided.

## Resident Physician Working Hours

The AMA Council on Medical Education submitted a far-reaching report setting forth 10 guiding principles on issues of resident working hours and supervision.

The Council asked the House to:

- recognize that problems exist with regard to resident supervision, which may compromise the educational program, the health of residents, and patient care
- urge the ACGME to revise the Essentials of Accredited Residencies in GME to emphasize the importance of resident supervision, work hours, and stress
- urge each Residence Review Committee to revise its Special Requirements to define the supervision and the maximum work hours to avoid excessive stress and fatigue, to assure quality patient care and to attain the objectives of the educational program.

## Nursing Education and the Supply of Nursing Personnel in the United States

The House adopted a report that concluded that a shortage of nurses impacts safe and effective medical services in hospitals and the home.

The Board called for incentives that will effectively help recruit, retain, and encourage the continuing formal education of skilled personnel who will work at the bedside in hospitals.

The House approved the following recommendations to address this growing problem:

1. Support all levels of nursing education, at least until the crisis in the supply of bedside care personnel is resolved.
2. Support government and private initiatives that would facilitate the recruitment and education of nurses to provide care at the bedside.

3. Support economic and professional incentives to attract and retain high quality individuals to provide bedside nursing care.

4. Support hospital-based continuing education programs to promote the education of caregivers who assist in the implementation of medical procedures in critical care units, the operating and emergency rooms, and medical-surgical care.

5. Cooperate with other organizations concerned with acute and chronic care to develop quality educational programs and methods of accreditation of programs to increase the availability of caregivers at the bedside and to meet the medical needs of the public.

## AMA Budget, Fiscal 1988

The House considered the 1988 plan and budget and commended the Board and its Finance Committee and the Executive Vice President for their skillful management of the Association's financial resources.

The budget includes operating revenues of \$165,870,000 and operating expenses of \$163,090,000.

## AMA Membership

The House learned that the AMA made record-breaking membership gains in 1987 resulting in an increase in AMA market share.

## Membership Incentive Program

The House adopted a Board Report describing the implementation of a financial incentive program designed to reward state medical societies for achieving AMA membership growth beyond established revenue goals based on each state's own past performance.

## Members Insurance Plan

The House approved a Board of Trustees recommendation to form an in-house, for-profit insurance agency subsidiary to handle the administration, brokerage, and marketing of the AMA's insurance



plans. These plans will now be offered to non-members. This expansion of the target market is designed to result in augmentation of non-dues income and increased profitability to the AMA.

### **Resident Physician Involvement in AMA**

The House adopted a resolution asking the AMA to determine the number of AMA delegates allocated to each state due to resident physician membership and to encourage equitable resident representation in each state's AMA delegation.

### **FMG Participation**

The House adopted a resolution asking the AMA to offer encouragement and assistance to state and county medical societies in fostering greater participation of foreign medical graduates in leadership positions at all levels of organized medicine.

### **Medical Staff Participation in the Joint Commission Site Surveys**

The House voted to have the AMA work with the Joint Commission to assure that appropriate members of the medical staff, along with their designated support personnel, represent the medical staff during the Joint Commission site survey.

### **Contractual Relations — Alternative Health Plans**

The House called for an AMA study on the implications of hospitals' contractual relationships with alternative health plans.

### **The Role of the Hospital Medical Director**

A resolution was adopted calling for the development of guidelines for the role of medical director that will maintain the autonomy of the self-governing medical staff and encouragement of a cooperative and effective relationship between the medical staff and the medical director.

### **Harvard/AMA Relative Value Study**

The Board of Trustees submitted a status report on the Harvard/AMA Relative Value Study, a national study of resource-based relative value scales for physician services. Several resolutions on the issue were also introduced and referred for action.

One resolution asked the Board to develop criteria by which the Relative Value Study could be evaluated seeking input from the various national specialty organizations.

Also, the resolution asked the Board to develop recommendations for implementation of the RVS, assuming acceptance by the AMA, to include both specific methodology and time to achieve full realignment.

### **Conclusion**

AMA House meetings provide a unique opportunity and I would encourage you to attend and participate. Any member of the Association may present testimony at the Reference Committee hearings and, of course, corridor discussions on the issues provide additional opportunities to get your views across.

If you can't come to the meeting you can still be represented through your delegate. Let your delegation know your opinions. You can also prepare a resolution and request that it be submitted to the House.

Many AMA policies began with an individual physician who had a good idea and coaxed it through the democratic process.

this was the mission which the IPA was originally conceived to fulfill, and it has emerged as the principal activity of the GHN venture. Also during 1987, the GHN Board of Directors made the difficult decision to suspend marketing of our HMO health insurance product.

The decision by the Board of Directors to cease marketing our HMO was a difficult one, but was virtually dictated by widespread underpricing in the health insurance market. Virtually none of the insurance companies operating in Georgia during 1987, whether HMO or traditional indemnity plans, was profitable. Group health insurance premiums have risen dramatically since the last quarter of 1987, and all signs are that the insurance market will remain unstable for some time to come. Such instability makes the pricing of HMO products extremely risky, and the risk for GHN is magnified by our thin capital position.

Under the circumstances, the most prudent course for our company was to minimize our exposure, protect our capital position, and reenter the market at a more favorable time. This does *not* mean that the HMO is out of business. The insurance company is quite solvent — and the Board's decision is intended to assure that it stays that way — and we retain our insurance charter and license. In the meantime, our insurance company continues to be courted by potential joint venture partners.

On the other side of the equation, the factors that are negative for the insurance industry underscore the positive need for GHN and in its primary role as IPA. As premiums have risen, there have been predictable attempts by insurers and other third parties to "control costs" in ways that adversely affect patient care or attempt to cast greater economic risks upon individual physicians. In addition, Medicare has already committed itself publicly to the development of physician

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## **GEORGIA HEALTH NETWORK**

**S. William Clark, Jr., M.D.**

**D**uring 1987, Georgia Health Network — as IPA — continued in its role as physician advocate in the medical marketplace;



PPO's, and CHAMPUS will undoubtedly pursue its plan to put most of military health care into a "pre-paid, managed-care plan." One of the primary missions of GHN is to negotiate on behalf of its members to assure that such third-party plans are "doctor friendly," to the extent that is possible in today's environment.

From an historical perspective, GHN has already produced many of the positive results that were predicted in 1985. As a result of the organizational efforts of GHN: a) Georgia physicians' understanding and level of consciousness have been raised about many of the technical aspects of managed care; b) Georgia physicians individually are better equipped to critically evaluate managed care agreements; and c) Georgia physicians are legally able to speak with a single voice on matters of common concern. Stated differently, GHN is having a fundamental and beneficial impact on the medical/economic environment in Georgia.

During 1986-87 in Georgia, we saw:

- The federal government — through CHAMPUS — dealing directly with GHN, and with the national consortium of physician groups that spun-off from Georgia's program (the Alliance of State Physician Networks).
- Since GHN published its "Principles of Contracting," managed care programs have faced an increasingly knowledgeable and independent group of physician prospects. When some managed care programs unilaterally moved to individual physician capitation systems, they saw large numbers of individual doctors choose to discontinue their participation.
- GHN has developed an in-house contract analysis program, and member physicians are taking advantage of that service to strengthen their bargaining po-

sition with the third parties who tend to draft such agreements with primary emphasis on their own economic interests.

- Without a doubt, the presence of GHN in the marketplace has brought about change in the way "managed care" is managed, although it is difficult to precisely quantify those influences. GHN continues to negotiate, as IPA, with three of the larger employer coalitions in Georgia to assure that their programs are "physician friendly." And, in response to a GHN Freedom of Information Act demand, HCFA produced the MAAC data that all Georgia physicians need to make the critical participation decision in that largest of managed care plans, Medicare.

Predictions are risky in this volatile field of medical economics. But into the foreseeable future, the MAG-sponsored IPA will continue to be uniquely positioned as the only statewide, physician-sponsored entity that can monitor, educate, and negotiate for its physician members across the entire spectrum of medical economic activities.

As we look to the future, it is important for us to remember why we are in this venture in the first place. Maximizing physician influence in the emerging medical marketplace, and with respect to "managed care plans" in particular, often requires that we make difficult choices among undesirable alternatives. We are now making those tough, undesirable decisions. But make them we must, if we are to have any control over the future of our profession. The alternative is to have them made by others less friendly to us.

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## JUDICIAL COUNCIL

**C. Emory Bohler, M.D.,  
Chairman**

**M**AG's Judicial Council is mandated to serve as the judicial authority of the Association. It functions as an appellate "court" to decide matters concerning membership, interpretation of the Constitution and Bylaws, disputes between county societies, medical ethics, etc. The vast majority of the Judicial Council's activities were carried out administratively without the necessity of formal meeting. Numerous requests for membership status changes and the review and appropriate response to licensure sanctions were handled through correspondence with each Council member. The Council's one formal meeting was to consider proper resolution of several appeals by members of changes in their membership status.

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## REPORT OF THE AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA

**Mrs. Maureen T. Vandiver  
(Roy W.), President**

**Theme for 1987-88 "Auxiliaries  
on the Move — Moving  
Expressly for Progress"**

### Organization

**T**here are thirty-five county auxiliaries including one reorganized county, Gwinnett-Forsyth Auxiliary. Others are: Baldwin, Bibb, Carroll-Haralson, Cobb, Colquitt, Crawford W. Long, DeKalb, Dougherty, Floyd-Polk-Chatooga, Franklin, Georgia Medical, Glynn, Gordon, Hall, Hart, Jackson-Banks,



Laurens, Medical Association of Atlanta, Muscogee, Newton-Rockdale, Ogeechee River, Peachbelt, Randolph-Stewart-Terrell, Richmond, South Georgia, Sumter, Thomas Area, Tift, Troup, Walker-Catoosa-Dade, Walton, Ware, Wayne, and Whitfield-Murray.

## **Directed by MAG Committee on Auxiliary**

Roy W. Vandiver, M.D., Chairman; Jack F. Menendez, M.D.; William C. Collins, M.D.; Ralph A. Tillman, M.D.; Maurice G. Patton, M.D.; David C. Thibodeaux, M.D.; Robert Burns, M.D.

## **MAG Committees**

Twelve (12) auxiliary members sit on MAG Committees.

## **Membership**

To date: March 14, 1988 — 2,224 members.

## **Auxiliary Executive Board**

The Executive Board of the Auxiliary to MAG is composed of ten (10) elected and two (2) appointed officers; all past state presidents; county presidents; and current chairmen of standing and special committees and committee members.

## **State Meetings**

*Post Convention Executive Board Meeting* — April 25, 1987 in Atlanta. Speakers: Jack F. Menendez, M.D., President, MAG; Mrs. Jean Hill (J. Edward), Southern Regional Vice President of the Auxiliary to the AMA; Mrs. Virginia Hopper (John), President, Southern Medical Association Auxiliary; Dr. Richard Dubois — on AIDS; Dr. Robert Burns — on Seat Belt Safety; Dr. Ed Waits — on the Impaired Physician Program; Dr. Dirk Huttenbach — on The Adolescent Urine Drug Screening Project.

*Summer Executive Board Meeting* — July 26-28, 1987 at Callaway Gardens. Workshops presented in the areas of Leadership Skills,

Membership, Parliamentary Procedure, The Dangers of Tobacco Products, and Seat Belt Safety/Occupant Restraint Seats for Children/Head Injury. An AIDS Education Seminar was presented. Invited Speakers: Ms. Rebecca Waide, President, Georgia Chapter of the National Head Injury Foundation; Douglas Skelton, M.D., Chairman, Georgia Task Force on AIDS; James H. Coil III, Esq., Labor Relations lawyer; Ms. Nancy Paris, Financial Development Manager, Visiting Nurse Association; Harold Katner, M.D., Medical Center of Central Georgia; Mrs. Marilyn Self, Director Health Services, Atlanta Chapter, American Red Cross.

*Winter Executive Board Meeting* — November 15-17, 1987, Atlanta — Seminar and Panel discussion on Alcohol and Drugs sponsored by the MAG Impaired Physicians Committee — Speakers: Jackie Cox, M.D., Staff Psychiatrist, Ridgeview Institute — "Drugs of Choice in the 80's"; G. Douglas Talbott, M.D., Program Director, Impaired Physicians Program — "The Dilemma of the Medical Marriage"; Noel Burtenshaw, Spiritual Counselor, Ridgeview Institute — "Spirituality in Addiction and Recovery." Workshops on Lobbying Techniques and Legislative Issues — Speakers: Ms. Maureen Lok, Chief Lobbyist, League of Women Voters; Senator Roy E. Barnes; Representative Eleanor Richardson. Workshop — Communication Skills — Speaker: Mr. Dave Partridge, Director of Public Relations, Greenville, S.C. Hospital System. Other Speakers: Mrs. Iris Bolton, Executive Director, Link Counseling Center — "Teen Suicide — Causes and Prevention"; Joseph Wilbur, M.D., Medical Director AIDS Program, Georgia Department of Human Resources — "AIDS Update."

*"Can We Talk" Lobbying Workshop* and visit from AMA Auxiliary Officers. Speakers: Representative Mary Jane Galer; Representative Dorothy Felton; Senator Bud Stum-

baugh; Senator Paul Coverdell; Mrs. Betty Szewczyk (Edward), President American Medical Association Auxiliary, Inc.; Mrs. Mary Strauss (Albert J. Jr.), President-Elect, AMA-A; Mrs. Sherry Strebel (Gary F.), Legislation Chairman, AMA-A; Mrs. Hazel Lewis, Executive Director, AMA-A.

*Legislative Day at the Capitol* — Please see section on Legislation.

*Annual Convention of the House of Delegates* — April 29-30, 1988 — Savannah, Georgia. Speakers: Mrs. Ann Pitchford, AMA Auxiliary Southern Regional Vice President; Mrs. Joan Milburn, President, Southern Medical Association Auxiliary; Jack F. Menendez, M.D., President, MAG; Joe M. Sanders, Jr., M.D., Director, Adolescent Medicine Services, Medical College of Georgia.

## **AMA Auxiliary and Other Meetings**

*AMA Auxiliary Annual Convention* — June, 1987 — in Chicago. Nine delegates attended.

*AMA-A Leadership Confluence I* — October, 1987 — in Chicago. The State President, President-Elect and six county presidents-elect attended.

*AMA-A Leadership Confluence II* — February, 1988 — in Chicago. The State President, President-Elect, Nominated President-Elect, and six county presidents-elect attended.

*Southern Medical Association Auxiliary Annual Convention* — November, 1987 in San Antonio, Texas. State President attended.

Southern Regional Meeting of the *White House Conference on a Drug Free America* — November 30-December 3, 1987 — Jacksonville, FL. State President attended.

*National White House Conference on a Drug Free America* — February 28-March 3, 1988 — Washington, D.C. State President attended.

## **County Meetings**

The A-MAG President visited the



following auxiliaries: Baldwin, Bibb, Carroll-Haralson, Cobb, Crawford W. Long, DeKalb, Dougherty, Floyd-Polk-Chatooga, Georgia Medical, Glynn, Gwinnett-Forsyth, Hall, Laurens, Medical Association of Atlanta, Muscogee, Newton-Rockdale, Peachbelt, Richmond, South Georgia, Sumter, Thomas Area, Tift, Troup, Walker-Catoosa-Dade, Ware, Wayne, Whitfield-Murray.

The President-Elect, the First Vice President, and the Area Vice Presidents traveled with the President at their convenience.

The President addressed the counties on the areas of Health Projects, Membership, Liability Support Groups, AMA-ERF, Legislation, and the Healthy Life Styles Campaign of MAG.

The Legislative Chairman traveled to several auxiliaries speaking on important legislative issues and encouraging legislative involvement.

### Publications

*Pulseline* — Four issues were mailed to every auxiliary member.

*Pulsations Newsletter* — Two issues were mailed to every auxiliary member.

*Auxiliary Directory* — The directory was updated to include member's first names and telephone numbers. It was mailed to each member.

*Annual Report* — Copies were mailed to each member of the Executive Board.

*Auxiliary Issue of the Journal of the MAG* — Copies were mailed to each member of the Auxiliary Executive Board in addition to the members of MAG.

### Projects and Programs

#### State

*AMA-ERF* — Funds were raised on a state and county level to be used for medical education and research. "No Smoking" pins were

made and sold in conjunction with our health project — The Dangers of Tobacco Products. The Holiday Sharing Card and a Silent Auction were also done on the state level. Physicians were encouraged to make their alumna contributions through AMA-ERF. Many activities such as auctions, luncheons, wine tasting, local sharing cards, the sale of wrapping paper and others were done on the county level.

*Membership* — A membership packet "Roadmap to Membership" was developed and distributed to every county president and membership chairman to offer ideas and encourage recruiting and retaining of members. The informational brochure "Did You Know" was also used throughout the state. Two workshops on membership recruitment were held for the county presidents and membership chairmen.

*William R. Dancy, M.D., Student Loan Fund* — is a loan to aid Georgia Medical Students with the costs



(L-R) The Journal editor and members of the Editorial Board: Charles R. Underwood, M.D., Marietta; Louis Sullivan, M.D., Atlanta; M. Julian Duttera, M.D., LaGrange; and William C. Waters, M.D., Atlanta. Members of the Board met over dinner to discuss current and future plans for the Journal.



of medical school. The fund was audited and policies were restructured to conform with the Trust Agreement drawn up between the MAG Foundation Inc. and the William R. Dancy, M.D. Student Loan Fund Committee.

*Doctors' Day* — March 30 — Auxiliaries were encouraged to have community service projects to honor the physicians in addition to social events.

### Legislative Programs

*Spouse Involvement Program* — was continued and spouses of physicians were encouraged to visit the Capitol to meet with their legislators to discuss pending legislation.

*Legislative Phone Bank* — The "Hot Line" phone bank was reorganized. Auxiliary members manned these phones four days a week throughout the Session of the General Assembly for the purpose of contacting physicians throughout the state and in designated areas encouraging them to contact their legislators on pending bills requiring immediate action.

*Key Contact Program* — This program was continued — matching the names of auxiliaries with those of legislators for the purpose of getting to know the legislators thus communicating to them medicine's views on certain legislative issues.

*GaMPAC — AMPAC* — One auxiliary from each congressional district served on the GaMPAC Board. The President served on the Board as an ex-officio member, and she also served on the GaMPAC Bylaws Committee.

*Legislative Day at the Capitol* — was a three-pronged effort:

- 1) Sponsored a program on Seat Belt Safety for Legislative Forum which is held each Tuesday during the Session of the General Assembly and is attended by representatives from civic, church, and volunteer groups for the purpose of receiving in depth background on legislation before the General Assembly.

- 2) Auxiliaries received a briefing by MAG legislative staff on issues of concern to medicine during the Session.

- 3) Spouses of legislators were invited as guests of the Auxiliary for lunch in an effort to increase communications. A program on AIDS education was offered following lunch.

National recognition was given to the Georgia Auxiliary during the 1987 AMA-A Convention in Chicago. Our "Hot Line" Phone Bank and Spouse Involvement Programs were chosen for presentation during county program previews. Only one other state was so recognized in the area of legislation.

### Health Projects

*AIDS Education* — Educational programs were presented to the Auxiliary Board Members at the Summer and Winter Board meetings. An educational packet "Fighting Fear with Facts" was developed in conjunction with the Medical Association of Georgia and distributed to every member of the Executive Board. Auxiliaries were encouraged to work in coalition with their local medical societies to present AIDS education programs in their communities. Many auxiliaries responded with programs for their members as well as their communities. The Auxiliary President and AIDS Education Chairman completed the Red Cross AIDS Education Facilitator Course. Approximately thirty (30) other Auxiliary members in four counties have also completed this course and have presented programs to schools, and community groups across the state. The Auxiliary President served on the MAG AIDS Task Force.

*Seat Belt Safety* — The A-MAG President and state Safety Chairman attended a workshop on Occupant Restraint Seats and Seat Belt Safety in Chapel Hill, N.C. in May of 1987. Based on the information gathered, a workshop was presented at the Summer Board Meeting

to educate board members and county auxiliary presidents. A workshop was presented in cooperation with the Cooperative Extension Service by the Whitfield-Murray Auxiliary. Three auxiliaries in the northern part of the state were also represented. This workshop keyed in on child restraint seats and their proper and improper use. This project was highlighted in the March issue of the AMA-A magazine *Facts*. In this area auxiliaries worked toward the passage of the Mandatory Seat Belt Law.

*The Dangers of Tobacco Products* — The Richmond County Auxiliary presented its Tobacco Hazards project at the Summer Board Meeting. Auxiliaries were encouraged to take this project into their communities. This project and all the "How To's" was presented at the AMA-A Confluences in Chicago. "No Smoking" pins were sold for AMA-ERF to further extend the message of the dangers of tobacco. The Muscogee County Auxiliary expanded on this project and presented "No Smoking Gift Packets" to 300 mothers of new babies born in the month of March in Columbus.

*"You Can Say No"* — Postponing Teenage Sexual Involvement — Phase II was initiated. Packets of materials continue to be distributed in the state and throughout the country. Ten (10) auxiliaries are training and presenting Dr. Marion Howard's "Postponing Sexual Involvement" program in their schools and to other organizations. A coalition of twenty (20) organizations interested in the teen pregnancy problem was formed in the Spring of 1987 and has continued to meet under the name of The Adolescent Coalition. Mrs. Barbara Tippins, Immediate Past President of the Auxiliary, was elected chairman of this coalition.

*Impairment and Drugs and Alcohol* — A workshop on Impairment was presented to the Auxiliary Board at the Winter Board meeting.



*The Adolescent Urine Drug Screening Project* was supported by the Auxiliary. Letters were sent to each county auxiliary president encouraging them to work with their medical societies to begin this project.

Many of the auxiliaries are working in coalition with other volunteer organizations presenting programs on the dangers of drugs and alcohol. The Auxiliary President attended the regional and national *White House Conference on a Drug Free America*. Two auxiliaries have distributed cards to local florists reminding teens not to drink and drive. These are placed in corsage boxes and delivered with the flowers for dances and during the prom season. A brochure entitled "Like Say No To Drugs Man and Say Yes To Life" was developed by Mrs. Laura Crawley of the Walker-Catoosa-Dade Auxiliary and used in a packet of materials given to teens at a Teen Health Workshop at the University of Tennessee in Chattanooga sponsored by the Tennessee Medical Auxiliary.

*Suicide Prevention* — Educational materials were distributed to every county auxiliary and every executive board member. Mrs. Iris Bolton, Director of the Link Counseling Center in Atlanta and a nationally known Suicidologist, spoke to the Executive Board at the Winter Board Meeting. The Richmond County Auxiliary working in coalition with the Richmond County Mental Health Association and the school board developed a flyer warning of the danger signals of suicides which were distributed to 33,000 households in Richmond County with report cards.

*Child Abuse Prevention* — The puppet show "It's OK to Tell" continues to be shown in the schools by several of our county auxiliaries.

*The Learning Center* — The catalogue was revised, reprinted and distributed to every county auxiliary. The Learning Center was displayed at the Auxiliary Summer Board meeting; the Wellness Week

meeting in Jekyll Island in June sponsored by the State Department of Education and the Department of Human Resources; and at a meeting of the State Health and Physical Education Coordinators at the Falcon Inn Complex in Suwanee, Georgia in August, 1987.

*Older Americans* — The distribution of medi-file cards continued.

*Liability Support Groups* — The A-MAG President continued to serve on this MAG committee. Encouragement was given to each county auxiliary to work with their medical society to form such groups. Brochures on *How To Form A Liability Support Group* and *Tips on How to Support* were sent to counties within the state and out of state to Indiana, Illinois, and North Carolina.

*The Surviving Spouse — How to Cope* — This special committee has developed a booklet to aid the spouse of the physician in the settling of the estate and selling the practice following the death of the physician.

### County Programs and Projects

The county auxiliaries are encouraged to participate in projects that meet the needs in their individual communities taking into consideration the number of volunteers and volunteer hours they have to expend. Many have participated in the health projects described above. However, they are also involved in numerous other projects which do meet needs in the local communities. Some of these include: Health Fairs, Screening for high blood pressure, vision, self breast examinations; funding loans for students in medically related fields; Adopt-a-School Programs; Rape Crisis Centers; purchase of eye glasses for needy children; CPR training; Hospice; Community shelters; blood drives; and many more. The work of the Auxiliary is carried out at the county level. The state and national levels of the federation provide materials,

ideas for programs and projects, leadership training and motivation.

The county auxiliaries are encouraged to work in coalition with other volunteer organizations and with their local medical societies. Many of our auxiliary members are also members of other organizations. Volunteer hours can best be utilized by the sharing of talents and time.

On behalf of the members of the Auxiliary to the Medical Association of Georgia appreciation is extended to the members of the MAG Committee on the Auxiliary and the MAG Board of Directors for their continuing support.

A hearty thank you is also extended to the MAG staff members for their help and advice throughout this year.

Thanks to *all* of you, we have been "Auxiliaries on the Move — Moving Expressly For Progress."

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## RESIDENT PHYSICIAN SECTION

**Greg Foster, M.D.,  
Chairperson**

**T**he Medical Association's Resident Physician Section (RPS) represents all of MAG's intern/resident members. As of this writing, the RPS has 538 members, reflecting continuing interest by interns and residents in MAG and its component county societies.

County societies' efforts remain central to MAG's resident membership. Vigorous recruitment during the past year has been conducted by the Muscogee County Medical Society, Medical Association of Atlanta, Bibb County Medical Society and others. A vital factor in resident membership recruitment is also the cooperation of the local teaching hospital. In several areas of our state, the hospital Director of Medical Education assists in orientation



sessions for residents about the MAG, or contributes toward payment of the residents' membership dues.

This year, MAG Mutual Insurance company continues its generous offer of paying county and MAG resident dues, up to \$45 total for interns and residents joining MAG for the first time.

The challenge before MAG's RPS is to derive from our membership a cadre of residents willing to involve themselves actively in the activities of our section and of MAG as a whole. We have discussed several tactics toward this end, particularly those that elicit some measure of participation without attendance at meetings (which is hard for many residents).

Having attended the AMA House of Delegates meeting last year, I wish to express my appreciation to the Medical Association of Georgia for its support and funding of our Section. We will continue our efforts toward securing resident membership and involvement in MAG.

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### MEDICAL STUDENT SECTION

**Bonnie Brinson,  
Chairperson**

**T**he purpose of the MAG Student Section is to provide student participation in the activities of the Medical Association of Georgia and the American Medical Association to develop medical leadership; to promote activity within organized medicine on the local, state, and national levels; and to work cooperatively with other student groups.

The Executive Council is elected once yearly at the annual meeting of the MAG Medical Student Section. This year the officers were Chairperson Bonnie Brinson, Mercer; Vice Chairperson Chris Larsen, Emory; Secretary Chandra Webb,

Morehouse; Delegates — Gus Stephens, Morehouse; William Tidmore, Emory; Scott Fowler, MCG; Richard Culp, Mercer. The Executive Council members act on behalf of the MSS members throughout the year. Their activities included advancing and monitoring interests of the MSS; promoting the MSS resolutions in the AMA MSS meetings; developing organizational programs; providing communication between MSS chapters within the state and between AMA MSS members nationally; and recruiting new members to the MAG MSS.

The Executive Council had three projects for this past year. The first was the recruitment of new members for the MAG MSS and AMA MSS. For their efforts and success Richard Culp and William Tidmore were awarded plaques at the AMA-MSS interim meeting in Atlanta. The second project was to host a mixer for the AMA-MSS delegates who attended the interim meeting in Atlanta. With each school MSS contributing funds, we reserved a room at Fitzgerald's and arranged for cocktails and hors d'oeuvres to be available for the delegates on Friday, December 5, after the committee meeting ended. This was to provide an atmosphere that contributed to discussion of the resolutions that had been presented earlier in the day and to promote the establishment of communications contacts nationwide. We also wanted to show the meaning of Southern Hospitality. From all of the positive feedback that we received from other states' school delegates, we believe that the mixer was a huge success. The third project that we had this year was to prepare a resolution addressing Medical Student Liability. We based our resolution on the Georgia Bill which addressed this problem in the state of Georgia and which the MAG backed. With very little discussion this resolution was unanimously passed by the AMA MSS assembly and referred to the AMA House. The following is

the resolution which sent to the AMA House of Delegates and subsequently referred to the Board of Trustees:

RESOLVED, that the American Medical Association investigate the prevalence of problems regarding medical student liability insurance and report its findings at the 1988 Interim Meeting.

The Executive Council feels that we have had a very successful year with the positive outcome of our projects. We plan to hold our annual meeting April 16 with plans to elect new officers next year and to develop resolutions for submission for the annual AMA MSS meeting in June.

The MAG-MSS members and Executive Council want to thank the Medical Association of Georgia members, delegates and staff for their guidance and help in nurturing our medical education in all aspects from classroom and clinical experience to developing our leadership abilities.

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### COMMITTEE ON THE AUXILIARY

**Roy W. Vandiver, M.D.**

#### Committee Members

Roy W. Vandiver, M.D., Chairman; Jack F. Menendez, M.D.; William C. Collins, M.D.; Ralph A. Tillman, M.D.; Maurice G. Patton, M.D.; David C. Thibodeaux, M.D.; Robert Burns, M.D.

The first meeting of the Committee on Auxiliary was held April 4, 1987. The Committee met to review and approve the Auxiliary's proposed budget and plans for the year. All committee members were present. Also in attendance were Mrs. Talitha Russell, Executive Director of the Auxiliary; Mike Fowler, Executive Director of MAG, and the spouses of the Committee members.



The second meeting took place at the Auxiliary Post Convention Executive Board Meeting and luncheon at the Hyatt Ravinia on April 25, 1987 in Atlanta. The members of the committee were introduced to the Auxiliary Executive Board by the Chairman of the Committee. Speakers were heard in the areas of AIDS Education, Seat Belt Safety, The Impaired Physicians Program, and the Adolescent Urine Drug Screening Program.

The third meeting of the committee will be held in Savannah at the Annual Convention of the House of Delegates on April 29, 1988.

## Auxiliary Programs & Projects

### Health Projects:

**AIDS Education** — Educational programs were presented to Auxiliary Executive Board members at the Summer and Winter Executive Board Meetings. Auxiliaries were encouraged to work with their medical societies to present AIDS education programs in their communities. An educational packet "Fighting Fear with Facts" was developed in conjunction with the MAG and distributed to every county auxiliary. The Auxiliary President and Auxiliary AIDS Education Chairman completed the Red Cross AIDS Education Facilitator Course.

Approximately thirty (30) auxiliary members in four county auxiliaries also completed the Red Cross AIDS course have presented programs to schools, and community groups across the state.

### Seat Belt Safety

A workshop was presented to the Executive Board in July. Educational materials including kits from General Motors were distributed to every county auxiliary. A workshop on Child Restraint Seats was held in Dalton, Georgia, in coalition with the Regional Coordinator of the Child Safety Seat/Safety Belt Program of the Cooperative Extension Service. The county auxiliaries

worked to educate their members on the importance of proper installation of child restraint seats and use of seat belts.

### Substance Abuse

*The Tobacco Hazards* slide show and presentation of the Richmond County Auxiliary was presented at the Summer Executive Board Meeting. Auxiliaries were encouraged to take this program into their communities. This project and all "How To's" was exhibited at AMA-A Confluence I and II in Chicago.

The Auxiliary President attended the regional and *National White House Conference on a Drug Free America*.

### Drugs and Alcohol

A workshop on *Impairment* was presented to the Auxiliary Board at the Winter Executive Board meeting.

### Adolescent Urine Drug Screening Program

Letters were written to each county president encouraging them to work with their medical societies to begin this program.

### Suicide Prevention

Educational materials were distributed to every county auxiliary and all executive board members. Mrs. Iris Bolton, a nationally recognized Suicidologist, spoke to our Executive Board in November. A program was developed in Richmond County reaching 4000 families with a flyer stating the danger signals of suicide. The flyer was sent home with the report cards.

### "You Can Say No" Postponing Teenage Sexual Involvement

Phase II was initiated. Kits developed by MAG continue to be distributed in the state and across the country. Ten (10) auxiliaries are training and presenting Dr. Marion Howard's "Postponing Teenage Sexual Involvement" Program in their schools and to other organi-

zations. A coalition of twenty (20) interested organizations was formed.

### Child Abuse Prevention

The puppet show "Someone To Talk To" continues to be shown in elementary schools.

### Learning Center

The catalogue was revised, reprinted, and distributed to every county auxiliary. The center was displayed three (3) times.

### Medical Society/Auxiliary Projects

The Auxiliary has continued to work with the medical society in the areas of AIDS education, adolescent urine drug screening, impairment physicians and spouses programs, and malpractice support groups.

### AMA-ERF

No smoking pins were produced and sold. The holiday sharing card, a silent auction, and wrapping paper were just a few fundraisers used this year for medical education and research. Physicians were encouraged to make their alumna contributions through AMA-ERF.

### Surviving Spouse — How To Cope

A special committee developed a booklet to aid the spouse in settling the estate and selling the practice following the death of the physician.

### Legislative Programs

*The Key Contact Program* has been continued.

### Spouse Involvement Program

Spouses of physicians from across the state continued to visit the Capitol to meet with their legislators to discuss pending legislation.

### Legislative Phone Bank

Reorganized "Hot Line" Phone Bank. Auxiliary members manned



these phones four days a week throughout the session of the General Assembly. The purpose was to contact physicians in designated areas to contact their legislators on pending bills requiring immediate action.

### *Legislative Day at the Capitol*

The Auxiliary participated in the *Legislative Forum* — made up of civic groups, church groups, etc. for the purpose of receiving in-depth background on legislation before the General Assembly. The Auxiliary sponsored a program on Seat Belts.

The spouses of the legislators were invited to join the Auxiliary for lunch in the Floyd Room of the Twin Towers Building in Atlanta in January. A program on AIDS Education was presented following lunch.

A "Can We Talk" Lobbying Workshop was held in December at the Academy of Medicine. Two state Senators and two Representatives presented a panel discussion on Lobbying and then small groups were led by legislators for further discussion of pending legislation.

### *William R. Dancy, M.D. Student Loan Fund*

This is a project to help Georgia residents with costs of medical school. Policies have been restructured to conform with the Trust Agreement between the MAG Foundation, Inc. and the William R. Dancy, M.D. Student Loan Fund Committee.

### *Membership*

A membership packet "Road Map to Membership" was developed and distributed to every County President and Membership Chairman to offer ideas and encourage recruiting and retaining of members. The information brochure "Did You Know" was also used throughout the State.

### **Meetings**

The President of the Auxiliary has attended the following:

*State:* Post Convention Executive Board Meeting, April 25, 1987, in Atlanta; Summer Executive Board Meeting, July 26-28, 1987 at Callaway Gardens; Winter Executive Board Meeting, November 15-17, 1987, at the Marriott at Perimeter Center, Atlanta. "Can We Talk" Lobbying Workshop and visit by AMA Auxiliary National President, President-Elect, Legislative Chairman and Executive Director, December 7, 1987 at the Academy of Medicine in Atlanta; and the Annual Convention of the House of Delegates April 29-30, 1988 in Savannah.

*National:* Annual Convention of the AMA Auxiliary House of Delegates, June, 1987 in Chicago. Leadership Confluence I and II in Chicago in October, 1987 and February, 1988.

*Southern Medical Association Auxiliary:* Annual Meeting in San Antonio, Texas in November, 1987.

*White House Conference on A Drug Free America:* Regional Conference November 30-December 3, 1987 in Jacksonville, Florida and National Conference February 28-March 3, 1988 in Washington, D.C.

*County Visits:* Visited twenty-five (25) county auxiliaries.

### **Publications**

*Pulseline* — Four issues a year.

*Pulsations* — Two issues a year.

*Directory of The Auxiliary* — received by every Auxiliary member.

*Annual Report* — distributed to each member of the Executive Board.

April Issue of the *Journal of the MAG* was the Auxiliary special issue.

## **BUILDING & LAND COMMITTEE**

**H. Duane Blair, M.D.,  
Chairman**

**G**rowth in the area of MAG Headquarters has proven unparalleled in recent years. We have seen the construction of the nearby Marta Station, a 610,000 square foot office building, and a multi-story hotel. The corner of Peachtree and 10th Street is now under construction and plans indicate within a few years this area will be an even more desirable location.

Last year at the time of the House of Delegates, the Building & Land Committee was approached by real estate investors interested in purchasing MAG's headquarters. Negotiations have been put on hold, but not before discussions indicated just how valuable our property is becoming.

The Building & Land Committee does not feel we need to rush into selling our building at this time. As long as we do not wait too long, we should be able to sell our building and find a suitable relocation site while establishing a substantial "cash reserve" for future needs.

## **CANCER COMMITTEE**

**LaMar S. McGinnis, M.D.,  
Chairman**

**T**he Cancer Committee planned to work with the Georgia Chapter of the American Cancer Society and others toward the development of a comprehensive, statewide Cancer Program.

The Cancer Society initiated this activity. Your chairman, other members of the Cancer Committee and staff are participating in the on-



going efforts to initiate this program throughout the state.

## IMPAIRED PHYSICIANS COMMITTEE

**Edward J. Waits, M.D.,  
Chairman**

The Impaired Physicians Committee met regularly throughout the past year, represented by Medical Directors of all the major treatment centers throughout the state, physicians treating alcohol and drug patients, and physicians active in MAG affairs. Outstanding among its many accomplishments were:

1. There was implementation of a Liaison Committee to the Board of Medical Examiners courtesy of Drs. Waits, Mooney, Gallegos and Jones. The objective of this committee is to examine and attempt to aid the Medical Board in dealing with impaired physicians and their licensure issues.
2. Meetings were held with the Auxiliary of the Medical Association of Georgia culminating in a dinner for the psychiatric residents of Emory, where the stresses of a resident's professional life, marriage, and personal life are examined in relationship to substance abuse.
3. The Fourth Annual Impaired Physicians Advocacy Workshop was held on December 12, 1987 in Atlanta in conjunction with the Winter Board Meeting of the Auxiliary to the Medical Association of Georgia.
4. Vigorous support was pursued for a half-time paid Medical Director which would be interim for two to three years until a full-time Medical Director is realized. The Executive Committee of the Impaired Physicians Program met with Dr. William Hard-

castle and his Committee to attempt to realize this desirable goal.

5. There was a suggested change in the name of the Program to "The Physicians Assistance Program" as the word "impaired" has gained undesirable legal interpretation which would profoundly negatively impact the physician who is in two to five years of recovery.
6. The addition of new members to the Committee as interest continues to grow in the Impaired Physicians Program.

Once again the Budget was held to the fifty thousand dollar limit, although the number of patients treated continued to grow. Alternative funding continued to be explored, as related to modestly raising licensure fee to support the program. The number of physicians treated in the MAG Program has now exceeded fifteen hundred.

## MATERNAL & INFANT HEALTH CARE COMMITTEE

**Luella M. Klein, M.D.,  
Chairman**

The Maternal & Infant Health Committee continues to review maternal deaths.

At this time, consideration is being given to identifying ways to deal with the problems associated with preterm deliveries.

The following statistical data was provided by the Georgia Department of Human Resources, Vital Statistics Department:

	Number			Rate		
	Total	White	Black	Total	White	Black
Live Births	98175	63474	33547	16.0	14.2	20.2
Age of Mother						
10-14	467	93	371	1.8	0.5	4.4
15-17	6362	2997	3346	37.4	26.1	60.2
Unwed Mother Birth Rate	26774	6746	19947	18.1	6.4	47.4
Age of Mother						
10-14	434	62	370	1.7	0.4	4.4
15-17	4402	1178	3212	25.8	10.3	57.8
Spontaneous Abortion Rate	6511	4155	2266	4.4	3.9	5.4
Age of Mother						
10-14	43	13	30	0.2	0.1	0.4
15-17	355	189	163	2.1	1.6	2.9
Induced Termination Rate	32154	17992	12948	21.7	17.0	30.7
Age of Recipient						
10-14	439	140	287	1.7	0.8	3.4
15-17	3593	2111	1385	21.1	18.4	24.9
Birth Weight						
<1500 gm	1556	660	882	1.6	1.0	2.6
1500-2499 gm	6411	3149	3209	6.5	5.0	9.6
2500-3999 gm	80573	51778	27786	82.1	81.6	82.8
>4000 gm	9635	7887	1670	9.8	12.4	5.0
% out of Hospital Births	634	295	316	0.6	0.5	0.9
Total Deaths	49336	35517	13729	8.1	8.0	8.3
Lifestages						
Infancy (<1)	1225	590	627	12.5	9.3	18.7
Neonatal	835	405	424	8.5	6.4	12.6
Post-Neonatal	390	185	203	4.0	2.9	6.1



### COMMITTEE ON MEDICAL ASPECTS OF SPORTS

**Letha Y. Hunter-Griffin,  
M.D.**

**T**he Medical Aspects of Sports Committee met to determine the content of the annual *MAG Sports Medicine Newsletter*. Topics chosen for the 1987 newsletter were: AIDS, The Coach and Pre-Season Medical Screening, A Guide to Examination of the Unconscious Athlete, Management of Soft Tissues of the Face in Athletic Competition, Low Back Pain in the High School Football Player, The Knee Brace Dilemma, Medical Concerns of Diabetic Athletes, Secondary School Athletes Deserve First Class Care, Sports Related Ocular Injuries, Nutrition In Sports and Home Health Care Guidelines. There was an insert placed in the newsletter entitled: Specialized Taping Techniques for the Injured Athlete.

Of continued concern to the Committee is the education of coaches. Discussion at each meeting focuses on whether to have a yearly or semi-annual sports medicine meeting for coaches put on by the Medical Aspects of Sports Committee. The question of where this meeting should be located has always been of concern.

As in the past, the Committee continues to support the ongoing sports medicine programs already in existence in the various counties, and to re-emphasize the Committee is willing to participate as speakers or provide educational materials to any of these ongoing programs.

Georgia has no process for certification of coaches as neighboring states have. At present there is no interest on the part of the school system to proceed in this direction. One offshoot advantage to such a certification program would be that

school systems would reimburse coaches for time spent at continued education courses. These could be the areas not only of prevention and treatment of injuries, but also First Aid and CPR.

Emphasis during the next year will be to publish our annual newsletter and to serve as educational sources for county school systems on issues of sports medicine.

The Chairman expresses appreciation to the members of the Committee who give a great deal of time to the writing of the newsletter: Fred L. Allman, Jr., M.D., John F. Atha, M.D., Robert L. Brand, M.D., Greg Foster, M.D., J. Nicholas Gordon, M.D., James F. Hammersfahr, M.D., Stephen C. Hunter, M.D., William B. Mulherin, M.D., William B. Strong, M.D., David T. Watson, M.D., Mrs. Talley Eddings, Robert Crow, M.D., and Talitha Russell of the MAG Staff.

### MEDICINE & HUMAN VALUES COMMITTEE

**Richard B. Stewart, M.D.,  
Chairman**

**T**his committee met on November 5, 1987 to discuss what direction the committee should take, i.e., what can the MAG do to help physicians and their patients deal with the very real issues which demand the application of strong, sometimes conflicting, human values/mortality/ethics along with current medical treatment modalities.

After a lengthy discussion about the issues and the committee members' frustrations about the amount of time and energies expended to develop recommendations which are frequently not accepted, there was a consensus that it would make more sense to try to find out what physicians throughout the state would like to have the committee/MAG address.

The committee requested Dr. Payne to write an article for the *Journal of the Medical Association of Georgia* expressing the frustration of the committee and requesting that physicians respond by prioritizing their preferences for MAG recommendations relative to the following issues: indigent care; street people/homeless; care of the mentally ill; allocation of resources; AIDS; STD/herpes, etc.; organ transplants; abortions; reproductive issues (whole gambit); DNR; and euthanasia. It was agreed that the article would reflect the clear-cut moral issues involved and further request that physicians express their opinions as to how to deal with these issues, e.g., educational conferences, publications, etc. A "tear-out" could be included to allow easy response.

If little or no response is generated by the article, the committee feels that a consideration to dissolve would be in order.

### PRISON HEALTH CARE COMMITTEE

**Robert H. DeJarnette, Jr.,  
M.D., Chairman**

**T**he Prison Health Care Committee continues under the leadership of Dr. DeJarnette, and met four times during the past year. Funding for the program of accreditation and technical assistance conducted by this committee continues through a contract with the Georgia Department of Corrections. For the year 1987-88 the amount of this contract is \$45,744, paid in 12 equal installments over the fiscal year. This level of funding is expected to continue in the '88 to '89 contract which is currently being developed. Accreditation fees continue to be collected for all site visits conducted.

Members of this committee are



often called upon to conduct site visits for accreditation at both prisons and jails. During the year there were nine state prisons reviewed for accreditation, all being successful in gaining reaccreditation. Of these, there were two new facilities entering the accreditation process for the first time, those being Leesburg Institution in Leesburg, Georgia; and "Al" Burruss Correctional Training Center at Forsyth, Georgia.

Local jails are finding more difficulties in meeting the standards than do the prisons. One jail was not reaccredited upon site visit, but does plan to reenter into the accreditation process in July of 1988. During the past year there were three jails visited for reaccreditation, and two are currently scheduled in the next few months. Presently, there are about five jails about to move into new facilities which are preparing to enter into the accreditation process.

During this past year Dr. DeJarnette was appointed to the MAG Ad Hoc Committee on AIDS. This committee met several times through the summer, fall and early winter, and produced a report representing all areas of concern to the Medical Association. This report supported the AMA position on AIDS. Testing of inmates for AIDS is recommended in this report.

One member of the committee, Charles A. Meyer, Jr., M.D., of Augusta, has been appointed as representative from the Academy of Psychiatry and the Law to be a Board member of the National Commission on Accreditation. This appointment will certainly bring the activities of the National Commission closer to this committee.

Dr. Cassandra Newkirk, committee member, has served this past year as chairperson for the Georgia Chapter of the American Correctional Health Services Association. This committee and the Georgia Chapter cosponsored the Fourth Symposium on Correctional Health Care in Georgia, which was held

February 18-20, 1988 at the Atlanta Marriott Hotel at Gwinnett Place. Some very excellent programs were presented during this symposium, with the keynote speaker being David C. Evans, Commissioner of the Georgia Department of Corrections. At the awards breakfast on the 20th there were several accreditation certificates presented to facilities accredited by this committee. In addition, Dorothy Parker, staff person, was presented with a plaque "in recognition and appreciation of her many contributions which have set the standard for quality correctional health care throughout the State of Georgia." The award was presented to Dorothy by Dr. Newkirk.

In October, 1987, the committee endorsed the newly revised Georgia Jail Standards as those standards which will be used for accreditation of Georgia jails by this committee. These are the same set of standards developed last year by the Department of Community Affairs Commission to Revise Jail Standards, on which Dr. DeJarnette served. In January, 1988, the committee unanimously decided to endorse the National Commission Standards on Prison Health Care to use as their standards for accreditation of Georgia prisons. These standards will be voluntary during the balance of 1988, but mandatory beginning January 1, 1989. It is expected that this year will begin some activity working with accreditation of juvenile institutions in Georgia. This committee has endorsed the work of the Adolescent Committee of the American Academy of Pediatrics, who has just completed a study of Georgia juvenile institutions and made recommendations to the Governor's Coordinating Council.

Unfortunately, in February of this year, the committee experienced the loss of one of its very devoted members, Henry (Hank) A. Robinson, Jr., M.D. He was presented with a MAG certificate of appreciation and a Resolution unanimously passed

by the MAG Committee on Prison Health Care at its January 31, 1988 meeting, just a few days before his passing. Committee members, Floyd A. Bliven, Jr., M.D., and Charles A. Meyer, Jr., M.D., both of Augusta, Georgia, presented these tributes to Dr. Robinson. Dr. Robinson was a retired Army Colonel and was laid to rest at Arlington National Cemetery on February 17, 1988, with full military honors. During the seven years of his membership on this committee, he was highly regarded by his colleagues for his leadership in the field of correctional medicine.

This committee appreciates the support given by MAG and respectfully submits this report as information on the progress experienced during the past year.

## SCIENTIFIC ASSEMBLY COMMITTEE

**Roland S. Summers, M.D.**

Our recent Scientific Assembly, held last November in Atlanta, was another successful effort.

We had 772 registrants — a little off from our previous (1985) meeting, but certainly a good showing for the eleven specialty society meetings held during our weekend. A specialty-by-specialty breakdown of registration is below:

### Attendance by Specialty

Allergy and Immunology .....	47
Chest Disease .....	56
Neurology .....	49
Neurosurgery .....	37
Obstetrics-Gynecology .....	73
Ophthalmology .....	82
Otolaryngology .....	31
Pathology .....	144
Plastic Surgery .....	22
Psychiatry .....	121
Surgery .....	110
	<hr/> 772



We are especially pleased that the income from our registration fees and a modest commercial exhibit area not only offset our direct out-of-pocket expenses payments to participating specialty societies, publicity, hotel, audio visuals, etc.), but went significantly toward helping to pay MAG's indirect costs such as staff time.

Once more, our attendees overwhelmingly expressed their liking of the Ritz-Carlton Buckhead Hotel, so we will meet there again this fall, November 11-13.

Thank you for your support of our efforts.

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### COMMITTEE ON SPECIALTY SOCIETY RELATIONS

**Ellis B. Keener, M.D.,  
Chairman**

**T**he Committee on Specialty Society Relations met once during the past year. Fourteen of the specialty societies were represented. In addition the Committee has carried on extensive correspondence and telephone communications with all of the 26 medical specialty societies that comprise the makeup of the Committee.

The principal business of the Committee during the 1987-88 year has been to address the question of a possible merger, or reunification, of the spring meeting of the House of Delegates and the fall meeting of the Scientific Assembly into a single Annual Session, more-or-less as it existed prior to 1974.

Inasmuch as the Scientific Assembly is a forum of the specialty societies it was clear to the Committee that the level of participation by the specialty societies was critical to the success of a merger. It was also known that several of the

specialties who meet regularly at the Scientific Assembly consider that meeting to be their Annual Meeting. To change the meeting date of the Scientific Assembly, or to attach other meetings and activities to it could have a serious impact on the established Scientific Assembly.

Because of the foregoing, the Specialty Society Relations Committee made a strong effort to measure, as accurately as they could, the extent to which we could expect specialty societies to cooperate with a merger that might result in a different date for the Scientific Assembly and possibly a different format.

Twenty-three (23) of the twenty-six (26) specialties responded to the committee's efforts to get a feel for the level of specialty society participation in a merged House-Scientific Assembly meeting.

The majority opinion expressed was to leave the two meetings separate. Most of the specialty societies had established their meeting patterns following the separation of the House and Scientific Assembly in 1974 to accommodate their own needs and scheduled so as not to conflict with their national organizations. The study revealed very little interest in seeing the two separate meetings merged into a single Annual Session. The results of the Committee's study was duly reported to the Board of Directors at the meeting on February 20, 1988.

Medical specialty societies continue to grow as vibrant, involved and articulate representatives of their respective groups. They represent, perhaps, the fastest growing segment in all of organized medicine. They should be recognized as full partners by the Medical Association of Georgia as soon as possible and in the most meaningful way possible.

I want to thank all the representatives of the specialty societies for their participation in the business of the Committee and through them to convey our collective apprecia-

tion to the specialty societies for the support they have given to the Medical Association of Georgia and to organized medicine throughout the State.

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### TRUSTEE ADVISORY COMMITTEE

**Cyler D. Garner, M.D.,  
Chairman**

**L**ast year we completed conversion of the MAG Retirement Plan to a more predictable money purchase pension plan. This conversion had the dual effect of benefiting our employees while limiting MAG's financial liability should investment earnings not meet expectations considering recent developments in securities markets. This change has proven timely.

This new plan will provide employees a choice of investments to meet their individual needs. However, the new plan does not place MAG at risk beyond the annual contribution of 8% of eligible employees' salaries. This is a significant change from the previous retirement plan and safeguards the assets of the Association.

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### AD HOC COMMITTEE ON ALTERNATIVE SOLUTIONS TO NURSING CARE CRISIS

**Joseph P. Bailey, Jr.,  
M.D., Chairman**

**A**t the request of the MAG Board of Directors, the Executive Committee appointed this committee November 16, 1987 with the fol-



lowing charge:

"This Committee is established to evaluate possible solutions to the crisis created by deficiencies in the provision of nursing care in Georgia. Its recommendations will be submitted to the appropriate MAG authority for approval and subsequent implementation."

There is no question that a nursing care crisis exists in Georgia, particularly in Georgia hospitals. The reasons are many — e.g., change in nursing education; decline in nursing school enrollment; alternative positions available in nursing, medicine and business; increased intensity of hospital services; etc.

The committee recognizes that nursing may be represented by a number of different organizations. Every entity involved with nursing seems to be concerned and trying to develop ways to address the myriad of issues involved. Options vary depending on local factors.

The committee recommended, and both the Executive Committee and Board approved the following actions:

1. That the MAG and the GHA conduct a nursing care crisis conference, invitees to include a physician, nurse and administrative representative from each Georgia acute care hospital.

It is recommended that this conference be held as soon as possible (between now and spring) in Macon.

The letter of invitation would request that each hospital provide statistics relative to its facility: number of physicians in hospital; number empty; turnover; cost of nursing care; specific problems; ways they are dealing with them.

2. That the MAG write a letter to the Governor requesting that he appoint a multi-disciplinary task force composed of representatives from RNs, LPNs, hospitals, physicians, Board of Nursing, and educators (Board of Regents and Post Secondary Education) to look at all as-

pects of the nursing care crisis and develop ways to work together to resolve current and future problems.

Subsequent to these actions, it was learned that the Georgia Hospital Association (GHA) conducted a similar type meeting in October '87 and has plans to hold three regional conferences relating to nursing care the latter part of April '88. At the time of this report, consideration is being given to the possibility of MAG cosponsoring the regional conferences in lieu of the statewide meeting. It is not clear at this time if these regional conferences will sufficiently address the concerns of the MAG.

### AD HOC COMMITTEE ON LIAISON WITH GEORGIA OSTEOPATHIC MEDICAL ASSOCIATION

**Alexander H. S. Weaver,  
M.D., Chairman**

**T**his committee has not met this year.

The Georgia Osteopathic Medical Association would like the committee to continue as an existing forum to address mutual issues as they may arise.

### IMPAIRED PHYSICIANS OVERSIGHT COMMITTEE

**William R. Hardcastle,  
M.D., Chairman**

**T**he 1987 House of Delegates created the Impaired Physicians Oversight Committee as an Ad Hoc Committee of the Board of Directors to evaluate the continuation and direction of the Impaired Physicians Program. Specifically the Oversight Committee was directed to present a report to the Board of Directors concerning the following matters:

- a) The need for a permanent overview committee to evaluate the on-going Impaired Physicians Program;
- b) The need for program enhancements including employment of a full-time Medical Director;
- c) Other possible sources of funding including designating a portion of physician licensure fees, payments and/or donations by institutions treating impaired physicians, and solicitation of voluntary contributions;
- d) The finances of the entire Program including those of all related organizations such as the Caduceus Foundation; and
- e) Any and all other matters affecting the continued operation, direction and management of this worthwhile Program.

From the outset it was clear that there has been a great deal of misunderstanding surrounding the operation of the Impaired Physicians Program. Past misunderstandings were further complicated when G. Douglas Talbott, M.D., announced that his group practice, Georgia Alcohol & Drug Associates (GADA), would be leaving Ridgeview Institute early in 1988 to start an independent treatment facility in



Atlanta. GADA has had the responsibility for implementing and maintaining the Impaired Physicians Program for MAG, reporting administratively to the Impaired Physicians Committee chaired by Edward R. Waits, M.D.

Realizing the Program is in a state of flux, the Oversight Committee felt it appropriate to concentrate on future needs as opposed to rehashing past points of contention. Accordingly the full Oversight Committee met twice and various Committee members and MAG staff met on several other occasions to collect requisite information.

As background, GADA provided the following information concerning *past* activities of the Program:

- 1) Almost 100% of physicians completing treatment have returned to "useful practice."
- 2) In the last three years 481 physicians and 38 D.O.s have been treated through the Program.
- 3) Of this group approximately 12.5% were from Georgia.
- 4) Currently, two M.D.s are in active treatment, with 51 in Aftercare.
- 5) Regarding the \$50,000 budgeted by MAG last year a rough breakdown would show \$18,000 for part-time Medical Director, \$12,000 for group counselors in Aftercare, \$14,000 for counselors in Education & Training, \$4,290 in clerical costs and \$1,710 for miscellaneous items. All payments for personnel were made to GADA employees and associates.
- 6) Although we were not able to collect an exact count, most patients were treated through Ridgeview and GADA although there are nine treatment facilities approved in Georgia.

The Oversight Committee was impressed by the reported success rate of the Program. Also, the Impaired Physicians Committee volunteers should be commended for the amount of time they have de-

voted to this Program. The hours involved are worthy of note.

Perhaps as a result of the increasing demands placed upon these volunteers, the Impaired Physicians Committee, chaired by Dr. Ed Waits, has recommended the employment of a Medical Director housed at MAG. Under this proposal the Medical Director would have five major duties:

- A. Identification and verification of impaired physicians to improve the "penetration" rate;
- B. Coordination of medical interventions;
- C. Assessment of appropriate treatment and placement in selected facilities;
- D. Re-entry monitoring after physician returns to practice; and
- E. Solicitation of funding for the Program.

Regarding funding for this new proposal, a budget of \$50,000 is requested by the Impaired Physicians Committee for fiscal year 1988-1989. This would provide for hiring a Medical Director November 1, 1988, a secretarial position, payments to group counselors, travel & miscellaneous expenses. Until November 1, GADA and the Impaired Physicians Committee would volunteer services. This level of funding does not, however, include payment by MAG for professional liability coverage for the Medical Director nor MAG as the sponsoring organization.

During the fiscal year beginning June 1, 1989, the funding requirement would increase to \$85,000 to \$95,000 (excluding liability coverage) assuming the Medical Director continues to draw a salary of only \$40,000. During subsequent years, funding requirements will approach \$200,000 annually under the Impaired Physicians Committee's proposal.

The Impaired Physicians Committee would propose funding these costs based upon an annual \$50,000 contribution from MAG and a sur-

charge placed upon physician licensure fees if approved by the State Legislature. Alternative sources proposed by the Impaired Physicians Committee include assessing treatment facilities although this idea has not proved feasible in the past. Additionally, solicitation of grants from other groups such as liability insurance companies have been suggested.

With this background, it is appropriate to address specifically the five items which comprise the Oversight Committee charge:

- a) *Need for Permanent Overview Committee* — It was the consensus of the members that the Oversight Committee should continue if a Medical Director is hired. Should a Medical Director not prove a viable alternative, the Oversight Committee should not be reappointed.
- b) *Need for Program Enhancements Including Employment of a Full-time Medical Director* — This item resulted in extensive discussion among Committee members as well as members of the Impaired Physicians Committee. Basically of the 5 members of the Oversight Committee present at the last meeting, a vote of 3 to 2 was in favor of employment of a Medical Director.

The three members voting for the Medical Director felt this approach was the best way for MAG to insure the proper direction of the Program. This approach was viewed as the only hope to convince treatment facilities to help fund the cost associated with the program enhancements.

These members stated that if a Medical Director is approved, he/she should be employed by MAG considering recommendations from the Impaired Physicians Committee. These members also expressed the desire for a better definition of



the Medical Director's function and responsibilities.

The two members opposed to MAG's hiring a Medical Director cited their concern for MAG becoming too heavily involved in the practice of psychiatry. Additionally, these members were concerned about future funding sources to pay for the proposed enhancement and felt other alternatives are available to continue the Program.

In fact, all members present expressed the realization that \$50,000 required for 7 months of operation in 1988-1989 was only the "tip of the iceberg" and that costs could reach \$200,000 annually within two years. Since outside funding is not assured at this point, it might be imprudent to commit MAG too quickly to a proposal which could require an additional \$30 dues increase (above the current \$10 required to provide \$50,000 in funding).

Until such time that details become more certain, the Oversight Committee hopes the Impaired Physicians Committee will continue to coordinate the Program. Some alternatives discussed at the meetings are included in (e) below.

c) *Evaluation of Funding Scores* —

The Oversight Committee was unanimous in questioning whether a substantial MAG dues increase would be feasible to fund the proposed Medical Director. The Committee also expressed reservations concerning a license fee surcharge since there would be no guarantee the State Legislature would appropriate required funds.

The Committee felt the most logical source of funding would be institutions involved in treatment. The following is an average example of the level of current charges to a physician completing the Program through Ridgeway Institute:

29 days Inpatient Treatment	\$11,000
Psychiatric Evaluation	600
Coverage from GADA	3,300
Caduceus Outpatient Recovery	2,400
S.A.F.E. Center	3,800
<b>TOTAL COST:</b>	<b>\$21,180</b>

An objective Medical Director housed at MAG might help convince institutions of the appropriateness of paying the cost of coordinating the Program. In any case, the Committee felt that in the past certain treatment facilities have substantially benefited from MAG's Program and should help pay the cost of program enhancements.

d) *Finances of Entire Program* —

Due to the proposed changes in direction of the Program, the Committee did not delve into past financial arrangements beyond that discussed earlier in this report.

e) *Other Considerations* —

There was a consensus of opinion that the Impaired Physicians Program should continue; however, there were numerous ideas as to how the Program should be coordinated in the future. The Committee did not feel the Program would necessarily end because a Medical Director is not appointed. Some of the alternatives presented at Committee meetings follow and are not necessarily mutually exclusive. One proposal would envision increased coordination at the MAG staff level. This might entail utilizing members of the Impaired Physicians Committee promoting the Program around the state and discussing ways to receive treatment. A MAG staff member would be on call to arrange interventions and direct physicians needing treatment and their families to appropriate physicians or facilities.

Under this plan, the Impaired Physicians Committee might be provided funding to develop an

educational presentation, a statewide network of physicians willing to perform interventions, monitor aftercare, and the like. The Impaired Physicians Committee currently apprised of 29 members would take a more active role utilizing the resources available throughout the state.

Another suggestion would include aspects of the previous alternatives along with the establishment of a loan fund to help physicians in need of treatment. Such loan funds would anticipate repayment once the physician returns to active practice. The loan fund could be administered by the Impaired Physicians Committee.

Another possibility would be simply to provide funding to a particular treatment facility or group of facilities to coordinate the program under the auspices of the MAG Impaired Physicians Committee. Essentially, the current Program has worked in this respect with some attempt to allow treatment in other institutions in the state.

A corollary to this would be to identify a group practice interested in coordinating the Program again under the auspices of the Impaired Physicians Committee. This would alleviate the concern for MAG becoming too actively involved in direct identification and treatment of physicians needing help.

In summary, and perhaps expectedly, the Oversight Committee experienced a diversity of opinion among its members. Continuation of MAG's efforts to help physicians in need of care was *not*, however, a point of contention. On a 3 to 2 vote the Committee recommends employment of a Medical Director with the proviso that appropriate funding sources can be found to cover this Program enhancement. A number of alternatives were discussed which might at a minimum provide an interim plan while other



details are evaluated and funding sources "tied down."

As Chairman, I would like to thank the members of the Oversight Committee who have considered an extremely emotional and important issue for the physicians of Georgia. Members of the Committee are:

William H. Biggers, M.D.; Rupert H. Bramblett, M.D.; Mark Coppage, M.D.; Dave M. Davis, M.D.; James S. Goodlet, M.D.; Bob G. Lanier, M.D.; Dan B. Stephens, M.D.

Finally, on behalf of the Oversight Committee I wish to thank those physicians who have been instrumental in guiding MAG's Impaired Physicians Program since its inception.

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### AD HOC MAG IPA/ HMO STUDY COMMITTEE

**Richard W. Cohen, M.D.,  
Chairman**

**T**he MAG IPA/HMO Study Committee was established by the 1986 House of Delegates. The Committee is charged with the responsibility of studying and reporting on the activities and finances of the MAG IPA/HMO. In this regard, the Committee evaluated the progress of the IPA and HMO in accomplishing the goals and objectives implicit in the authorization passed during the 1985 Annual Session.

From an historical perspective, a Special Session of the House of Delegates was convened in October 1984 to address MAG's role vis-a-vis the proliferation of Alternative Delivery Systems in Georgia. At that time it was apparent that HMO's were beginning to establish a market base in the state. More importantly, it was apparent that other forms of alternative systems — PPO's, indemnity plans with stringent managed care components,

and the like — were on the verge of spreading throughout the state as major insurers moved toward offering "triple option" products, i.e., indemnity plans packaged with an HMO and other managed care products such as PPOs.

The questions before the House was the manner in which MAG should respond to the perceived threats that alternative delivery systems placed upon physicians' ability to practice quality medical care for the good of Georgia patients. In addressing this question the House considered the financial and administrative resources required under various proposals. And the House debated, at length, the philosophical aspects of such proposals.

All of this debate centered upon prognostications of future developments with the realization that if "one's worst fears materialized" individual physicians would be at the mercy of large insurers and for-profit health chains. Virtually none of the Delegates was supportive of the changes adversely impacting traditional modes of medical care delivery. It was apparent to the House that some action was required to preserve the quality of care delivered, and to insure organized physician input into the emerging trends.

As a result of the Special Session, a business plan was introduced at the regular House meeting in April 1985. After lengthy debate, the House approved establishment of a MAG-sponsored IPA with a separate health insurance component or HMO. Basically, the House approved a plan designed to give physicians a voice in the way medical care is delivered in Georgia.

Since that time MAG has developed an IPA, Georgia Physicians Health Network (GPHN), with some 2,400 physician members. Surprisingly, almost 65% of these members are outside the Atlanta area. Also, in January 1986, the Georgia Health System (GHS) — the HMO

component — was granted the first statewide license in Georgia. Collectively, GPHN and GHS are known as the Georgia Health Network (GHN). For clarity, the terms IPA and HMO will be used in the remainder of this report as appropriate since these are two distinct and separate entities.

It is important to remember that the IPA is the key or "center piece" of MAG's sponsored activities. The IPA is the entity with the greatest potential to meet the goals and OBJECTIVES implicit in the House's actions.

The basic tenets of the IPA and HMO can be summarized as follows:

- *Maintenance* of physician input in all professional aspects of medical care delivered to Georgia patients;
- The *provision* of quality medical care to Georgia residents;
- *Opposition* to payment mechanisms which do not provide proper incentives for quality care such as individual physician capitation, overly restrictive gatekeeper systems, and across-the-board fee discounts or discounts disguised as withholds;
- *Preservation* of those aspects of traditional medical practice to which physicians are dedicated within changing market conditions;
- *Establishment* of an organization with wide appeal among physicians that will become the example of contractual principles for all alternative delivery systems.

As we reported last year, we have seen growing dissatisfaction among patients and physicians with HMO's and with "managed care" in general. Some would argue that this will lead to a return to traditional delivery systems. It may well be that HMO's proliferation subsides, but the odds are that they will retain a place in the market (10-15%), with PPO's in various nuances, and in-



demnity insurance under strict managed care arrangements capturing the remainder of the market.

In a special report entitled "Health Care Outlook for 1988 — Turnaround" by Russell C. Coile, Jr., the following two statements appear applicable to our current situation:

"The battle is far from over, but PPOs pulled ahead of Health Maintenance Organizations in enrollment in 1987 and will broaden the gap in 1988," and

"Managed care is rapidly overwhelming all payment approaches. All buyers will manage their care. At the moment, HMOs are dead in the water. After three years of bruising competition, fewer than half of all HMOs are profitable."

These changes could severely impact our ability to practice in the best interest of our patients. Physicians must have a strong voice in the development of acceptable contractual relationships with these plans to assure fair treatment for both the patient and physician.

We have seen carriers offer contracts to physicians with across-the-board fee discounts. We have watched "withholds" become discounts and the physicians lose faith in promises that withheld fees will be repaid. We have witnessed hospitals propose PPO's allowing participation by only a small portion of physicians on staff.

We have seen physician fees capped at ever increasing percentile levels. We expect more HMO's to move to physician capitation and to tighten utilization review criteria which could adversely affect the quality of medical care. We have heard more and more talk of the use of "gatekeeper" systems to restrict freedom of patient choice.

In short, the fears which lead to the House's action in 1985 have materialized and will continue to become more and more prevalent. MAG's IPA is postured to help main-

tain physician control in critical areas of medical practice. As you will see in the remainder of this report, Georgia Physicians Health Network (the IPA) activities — beyond its relationship with MAG's captive HMO, Georgia Health System (GHS) — have not been easy and could not be termed an "overnight" success on paper. However, the IPA is taking steps toward accomplishing its goal of protecting those aspects of medical practice to which Georgia physicians are dedicated.

## HMO Activities

S. William Clark, Jr., M.D., in the February issue of the *Journal of the MAG*, made the following announcement:

"After careful analysis of the group health insurance market, the capital position of the HMO, and much soul-searching, the Board of Directors of the HMO voted to non-renew all existing insurance accounts as of December 31, 1987. . . . This *does not* mean that the HMO is out of business. . . ."

Effectively, this announcement stated that the HMO has been "mothballed." It is important to state at the outset that this decision, though regrettable, was wise, prudent, and courageous. The reasons for the decision are numerous and need to briefly be touched upon.

There are certain realities in Atlanta, as well as in the State of Georgia, with respect to HMO activities. These realities boil down to the fact that our HMO was running high costs for medical care, combined with low demand for our services, plus high utilization by patients, plus, because of the small number of covered lives, we had a disproportional number of high-risk patients and catastrophic cases. Add to this, relatively thin capitalization at the outset, as well as an extremely competitive HMO pricing market, leading to a basic under-

pricing of all HMO's as well as Georgia Health Network, and the net effect was impending financial disaster.

The choices were 1) to accept the above, continue on, and become insolvent within the next twelve months; or 2) to increase premiums to a point where we could break even and cover expenses on paper and thus further limit the attractiveness of our HMO; or 3) to successfully bid on several potential statewide contracts with utilization levels built at such a low level that they, too, would have been losing propositions; or 4) to consider selling individual packages which would further attract high-risk groups with continued catastrophic problems; or 5) The last option would have been to go into the Atlanta metropolitan area market to compete with deep pockets far greater than ours and, thus, assure nothing less than financial disaster.

The only realistic alternative after considering the options was to "mothball" the HMO and to wait for a brighter day. We still have an HMO license, and it is the only statewide HMO license. Having "mothballed" the HMO there are no on-going expenses referable to the HMO, and we can wait for a brighter day when prices have stabilized at a more realistic premium level and, in addition, look for an opportunity to increase our capital base.

Notwithstanding our experiences in the health insurance business, it is clear that much good has come from the HMO activity. Many may question where the silver lining could be, but the realities are that the physicians of the State of Georgia have come together, have formed under one umbrella, and have, therefore, taken a proactive stance in order to better secure the patient care within the state and to protect physicians rights. In addition the HMO increased substantially the education of the physicians in the State of Georgia regarding alternative delivery sys-



tems, and ultimately, we have been able to give physicians around the state the opportunity to take a second look at what HMO's really are and to develop a balanced view regarding the negatives as well as the positives of HMO's.

### IPA Activities

In retrospect, enough emphasis was not placed on educating our membership of the potential activities of the IPA. Many have continued to see the HMO as MAG's thrust in the area of medical economics. The fact is, the IPA is the "future" to fulfilling the goals and objectives expressed earlier in this report.

Dr. Clark, in his February report in the *Journal of the MAG*, made several statements worth repeating at this time:

"... (the) medical marketplace ... underscores the compelling need for Georgia physicians to be represented economically, and for GHN as the vehicle through which to exercise their influence. The primary mission of GHN is to negotiate on behalf of the members ..."

"From an historic perspective, GHN has already produced many positive results ... (a) Georgia physicians' understanding and level of consciousness have been raised about many of the technical aspects of managed care; (b) Georgia physicians individually are better equipped to critically evaluate managed care agreements; and (c) Georgia physicians are legally able to speak with a single voice on matters of common concern. Stated differently, GHN is having a fundamental and beneficial impact on the medical/economic environment in Georgia."

As a result of the foregoing feelings and philosophy, the Board of Directors of the IPA in December drew up a work program for the 1988

calendar year. This program has many facets, several of which have been on-going for the last three years and have reaped substantial benefits. It is hoped in the coming year that the IPA will be able to develop *local panels* or chapters to better represent and educate physicians in different regions throughout the state, thus creating a more formal network as well as lines of communication.

*Advocacy and representation* are truly "where it's at." The IPA, therefore, continues to serve as your advocate, representative, and educator regarding many issues. It is intended that the IPA will become active with the PRO to assist individual physicians, as well as all physicians, in their relationships with the PRO. At the request of the Third Party Relations Committee of MAG the IPA has developed a contract review service, in order to assist physicians who receive contracts from third parties such as HMO's, PPO's, and other alternative delivery contracts. The IPA will represent, educate, evaluate, and support our goals regarding legislative initiatives such as this past year's PPO legislation (H.B. 507) where both MAG and the IPA were instrumental in creating a bill that was supportive and protective of our interests. The IPA will continue and hopefully become even more active in the area of local alternative delivery system initiatives such as have occurred in Gainesville, Savannah, and Albany in the past year, and continue to act as an organizing body to represent IPA members within the local setting. Additionally, the IPA was able to represent members in the IPA regarding the dispute with HCFA and the obtaining of individual physician's "MAAC's" so that physicians would be able to make an informed decision regarding participation within the Medicare program. The area of advocacy is wide open and is considered a safe area for activity by the IPA.

Since the IPA is the only state-

wide panel of physicians, the possibility exists for negotiation of *PPO* contracts on both statewide as well as local and network bases. It is intended that any PPO activity that is entered into by the IPA, and any other discussions with alternative delivery systems, will continue the same principles that have been used for negotiation between the IPA and our own HMO. The principles have not been negotiable in the past and will continue in the future to remain non-negotiable. Through PPO activities it is possible to generate dollars to the IPA that can substantially offset the cost of running the IPA. And it is this area that may well be able to provide the IPA with financial self-sufficiency.

The IPA intends in the coming year to continue to *communicate* and to provide *education* to the individual members of the IPA through newsletters, county visits, and through constant communication with the Board of Directors of MAG and the House of Delegates of MAG.

Future thoughts for appropriate activities of the IPA may well encompass utilization review and quality assurance contracts as well as the establishment of a wellness program to help support MAG's "Healthy Lifestyles."

### Financial Results

From the outset, it has been obvious to this Committee that the financial aspects of these activities have proven difficult to communicate to the membership. All financial aspects concerning the IPA and HMO have been available through MAG's Annual Audit, reports to the Board and House; the "Proceedings" issue of *JMAG*; and financial reports by GHN.

However, it is clear that these reports have been extremely complicated considering the number and complexity of the entities involved. Notwithstanding these past communication problems, this Committee would like to present a concise picture of financial transactions to insure membership understand-



ing of what has transpired during the past three years. The following section summarizes financial transactions within MAG.

All expenditures related to the IPA/HMO, even those associated with the Special Session of the House of Delegates in October 1984, have been allocated to this project and charged against assessment proceeds. This allocation includes all MAG staff time chargeable to the project.

The \$650,000 of voting stock was carried as an investment on MAG's Balance Sheet for the year ended May 31, 1986. In fiscal year 1987, accounting conventions required MAG's auditors to "write-off" this investment since GHN experienced aggregate losses in excess of \$650,000. This "write-off" was a non-cash item during fiscal year 1987.

The \$500,000 in surplus certificates purchased during fiscal year 1988 are repayable to MAG. Expenditures such as the last \$400,000 approved by the Board in September 1987 will show as an expense on MAG's books when disbursed. They are not, however, considered as part of the Regular Operating Budget. Please note, these amounts are still within the funds originally assessed in 1985. Again, MAG dues have not been used to fund this project.

Consequently, funds in GHN of \$927,000 plus \$303,000 remaining provide \$1,230,000 available for the project. Graphically, this can be displayed as follows:

This summary fully delineates the financial transactions during the past 3 years. After careful review, this Committee is satisfied that all transactions have been appropriate and consistent with the language and intent of the original House of Delegates action in April 1985. In addition, we would like to reassure the members of the House that the IPA is solvent and that there are no dues monies contributed by the MAG for this project.

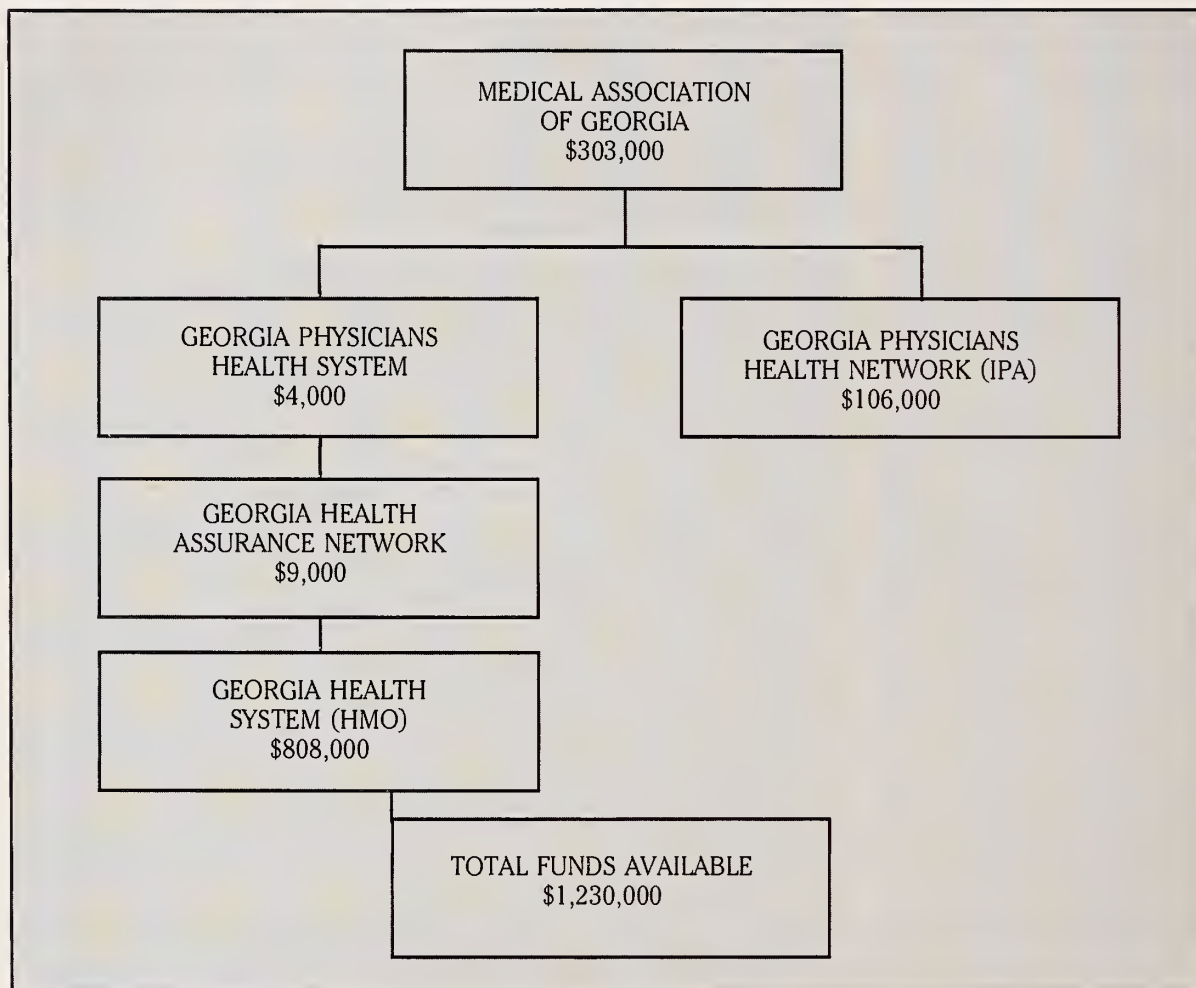
## Financial Activities Within MAG

Receipt of Assessment for Medical Economic Activity — June 1985-December 1985	\$2,506,000
Expenditures incurred by MAG for consulting, legal and educational activities — October 1984-February 1986:	
Salaries & Benefits	\$132,000
Legal Fees	181,000
Travel	11,000
Telephone, Printing, Office	57,000
Consulting	163,000
Data Processing	109,000
	(\$ 653,000)
GHN Voting Stock purchased by MAG — January 1986:	(\$ 650,000)
Sub-total Funds Remaining 5/31/87	\$1,203,000
Purchased of GHN Surplus Certificate by MAG — June-September 1987	(\$ 500,000)
Additional Commitments Approved by MAG Board of Directors — September 1987	(\$ 400,000)
"Unobligated" funds remaining in MAG — December 31, 1987	<u>\$ 303,000</u>

## Summary of Financial Results of GHN

Sources of Funds:	
GHN Voting Stock Purchased by MAG	\$ 650,000
Purchase of GHN Preferred Stock by Individual MAG Members	1,052,000
Purchase of GHN Surplus Certificates by MAG	500,000
Additional Commitment Approved by MAG Board of Directors, Sept. 1987	
	<u>400,000</u>
Total Sources of Funds	\$2,602,000
Uses of Funds:	
Gross Income (Premium Revenue Less Benefit Expenses):	
Calendar Year 1986 Income	\$ 28,000
Calendar Year 1987 Deficit	(\$ 570,000)
Administrative Expenses:	
Calendar Year 1986	(\$ 536,000)
Calendar Year 1987	(\$ 597,000)
Total Uses of Funds	<u>(\$1,675,000)</u>
Funds Remaining at December 31, 1987	<u>\$ 927,000</u>





## Report Summary

We are witnessing the maturation of a system developed to give physicians a voice in the way health care is delivered and financed, all consistent with the House of Delegates' actions of 1985. And we must not lose sight of the fact that the IPA is the only vehicle available to represent physicians' economic best interest and at the same time support the high principles and ideals regarding patient care and the delivery of health care within the State of Georgia.

We would again like to quote Dr. Clark in this article in the *Journal of the MAG*:

"... your MAG-sponsored IPA will continue to be uniquely positioned as the only statewide, physician-sponsored entity that can monitor, educate, and ne-

gotiate for its physician members across the entire spectrum of medical economic activity."

We, lastly, feel it is appropriate to restate the contracting principles which govern these activities.

- The IPA will OPPOSE individual physician capitation reimbursement systems; they inject incentives into the medical care system that are prejudicial to high quality patient care;
- The IPA will OPPOSE "gatekeeper" systems of case management; they, too, inject incentives that are prejudicial to high quality care and impose undue financial risks on primary care physicians;
- The IPA will OPPOSE straight percentage fee discounts; they penalize the efficient, low-cost physician even more severely

than the high-cost physician who is supposedly the target of these types of "controls" and do not offer proper utilization control incentives;

- The IPA will SUPPORT reasonable ceilings on fees to meet competitive marketplace forces, while adequately compensating physicians;
- The IPA will SUPPORT risk/incentive systems that provide for the return of monies held "at risk" if reasonably attainable cost-control criteria are met by the physician group;
- The IPA will INSIST that professional aspects of the practice of medicine (such as credentialing, quality assurance, utilization review, retrospective peer review, and professional discipline) be controlled by our bona fide professional peers.



In concluding, your Committee is satisfied that the Boards of the IPA and the HMO have acted openly, honestly, and decisively in their actions of the past year and after hearing all of the facts your Committee is supportive of the action to "mothball" the HMO and to redirect the emphasis toward creating a more efficient, more successful and, in the future, hopefully self-sufficient IPA that will be able to meet the challenges in the medical economic arena of the State of Georgia in a proactive rather than reactive mode.

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### AD HOC COMMITTEE ON PROFESSIONAL LIABILITY SUPPORT GROUPS

**Earnest C. Atkins, M.D.**

**O**ur Committee has continued to inform Georgia physicians and their spouses about the emotional and psychological stress of being sued for medical malpractice.

Last year the MAG House of Delegates passed a resolution urging county medical societies to sponsor "an educational program on the psychological and physical impact of liability lawsuits on physicians, and on the benefits of peer 'support groups' in alleviating these symptoms of malpractice stress." I am pleased to report that a number of societies have held these meetings, at several of which I or MAG staff have been invited as speaker: DeKalb Medical Society, Richmond County Medical Society, Hall County Medical Society, and Clayton-Fayette County Medical Society. I have also addressed the Troup County Medical Auxiliary on the subject of "Medical Malpractice — A Family Affair."

The 1987 House also resolved that the MAG should work with the major medical liability insurance carriers in the state to see that physicians are sent information on malpractice support groups when they notify their company of a possible or impending suit.

We have met with executives of both St. Paul and MAG Mutual on this point, and learned from them their concerns over publicizing or encouraging support group listeners for their insureds. The companies' concerns, we feel, are understandable: a sued physician, explaining the emotional stress he or she is undergoing, will likely divulge the clinical and legal details of his suit to the listener. In this way the "listener" involuntarily becomes involved in the lawsuit and may even be subpoenaed at the trial, even if the "listener" avoids giving any advice. Moreover, the insurance companies have a procedure of urging their insureds not to discuss the details of their cases with other parties; our suggestion that the companies encourage the sued physician to call a colleague, even an anonymous one, contravenes those procedures.

For these reasons, the companies felt it best that they refrain from involvement in further educating Georgia physicians about medical malpractice stress syndrome, and about our support group mechanisms.

Having discharged its duties, both as imposed by the House of Delegates over the past two years, and as imposed by our own Committee membership, we feel our *ad hoc* Committee merits dismantling. I therefore have plans, at the time of this writing, to recommend to the MAG Executive Committee that our Committee be abolished.

We have only been able to accomplish our mission during these two years through the energetic work of our committee members. I wish to commend them for their generous support and assistance:

Hoyt C. Dees, M.D.; David M. Nichols, M.D.; Mrs. Maureen Vandiver; Mrs. Jan Collins; Mrs. Barbara Tippins; Mrs. Pearline Thomas.

I would be remiss too if I did not express my hearty appreciation to Mrs. Talitha Russell and Dr. Steve Davis of our staff for their assistance and initiative. In travelling about the state speaking for the Committee I have gotten to know our staff more closely, and have richly enjoyed the experience.

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### AD HOC COMMITTEE ON RADIOLOGY TECHNOLOGISTS

**John D. Watson, Jr., M.D.,  
Chairman**

**T**he 1987 session of the Georgia General Assembly saw the introduction of House bill 143 which would have created a new two-tier system of mandated certification for any person operating X-ray and related equipment. The new "sunrise" statute requires an administrative review of any new licensure or certification to determine if there is a sufficient public "need" to require such governmental regulations. The "sunrise" law established the Occupational Regulation Review Council to study, review and approve, if appropriate, such potential regulation as proposed in HB 143.

The Radiology Technologists were well represented through their state association members and a professional lobbyist(s). Enormous amounts of materials and scientific articles were presented to the Occupational Regulation Review Council as part of its consideration. Several meetings were held with testimony being presented by such groups as chiropractors, podiatrists, dentists, nurses, family practitioners, the Medical College of



Georgia and MAG.

After careful and exhaustive review, the Occupational Regulation Review Council ruled that there was insufficient justification to authorize additional governmental regulation in the taking of X-rays. MAG's position was upheld. Attached is a copy of the Council's findings.

## ATTACHMENT

### Review of House Bill 143 Which Proposes to License Radiologic Technologists in Georgia

#### Executive Summary

As provided in O.C.G.A. 43-1A, the Georgia Occupational Regulation Review Council reviews all bills proposing licensure of a professional or business referred to it by the chairperson of the legislative committee of reference. Accordingly, the Council has examined House Bill 143 which proposes to license radiologic technologists at the request of the Chairperson of the House Health and Ecology Committee.

Radiologic technology is broken into the following three applications of medical radiation:

- Diagnostic radiation which is used by a practitioner to diagnose a problem
- Therapeutic radiation which is used to treat cancer; and
- Nuclear medicine which involves the use of a radiopharmaceutical inside or outside of a person's body to detect minute hormones or substances in a person's body.

Presently, radiologic technologists are not required to be licensed in this State.

During the course of this study, we obtained information from numerous medically-related organi-

zations and colleges, from experts in the fields of medical radiation, from manufacturers and from practitioners; performed analyses based on the resulting information; and prepared recommendations which are included in this report. We briefly describe our findings and recommendations in the following pages and present them in greater detail in other sections of this report.

#### Findings

Because the three kinds of medical radiation applications involve different practices and practitioners, we divided our findings by medical radiation application.

#### *Diagnostic Radiologic Technologists*

Based upon the criteria in O.C.G.A. 43-1A which the Council is required to use to make its basis for a decision, we found that the following conditions exist:

- The potential for harm or danger to the public is remote because evidence to the contrary was not provided to the Council. Additionally, all work performed by a radiologic technologist is reviewed by the physician, chiropractor, podiatrist or dentist who ordered the x-ray;
- Where specialized skills are needed, trained technologists are hired. In cases where technologists are trained on the job, the procedures performed are limited, easy to learn and repetitive and the percentage of the population served is small;
- Voluntary efforts to regulate the occupation are working. Additionally, the ultimate liability continues to rest with practitioners regardless of whatever delegation of responsibility is made to other employees of their practices; and
- There may be a disruption of service and an increase in the

cost of care as a result of regulation.

#### *Radiologic Therapeutic Technologists*

Present conditions concerning radiation therapy include:

- Safeguards exist in the system to assure a high quality of care;
- Specialized skills are needed, and trained personnel are hired to perform these procedures;
- The Joint Commission on the Accreditation of Hospitals and Medicare/Medicaid have established sufficient criteria to regulate the therapeutic practice; and
- There is no significant economic impact for the citizens of the State because this group is already comprised of certified practitioners.

#### *Nuclear Medicine Technologists*

- Experts agree the potential for harm or danger to the public is remote;
- Specialized skills are needed and trained personnel are hired to perform these procedures;
- The Nuclear Regulatory Commission has developed stringent standards to regulate the practice; and
- There is no significant economic impact for the citizens of the State because this group is already comprised of certified practitioners.

#### Recommendations

The Georgia Occupational Regulation Review Council recommends against regulation of radiologic technologist personnel in all three fields of practice as proposed under House Bill 143. Our research indicates that formally trained technologists provide at least 92% of all diagnostic radiation procedures administered and virtually all of the therapeutic radiation and nuclear medicine procedures provided. The proposed legislation will not im-



pact the public significantly because it is focused at a population which provides 8% or less of the medical radiation procedures administered.

House Bill 143 will primarily impact the private physician, chiropractor and podiatrist who typically train their medical staff to perform diagnostic x-rays. Physicians, chiropractors and podiatrists generally use diagnostic radiation for diagnosis purposes and find this procedure to be an integral tool of their practices. We believe that the continued use of medical radiation by persons who have not obtained formal training does not pose a threat to the public. Our reasons include:

- No solid documentation was provided to indicate that the level of radiation emitted by diagnostic X-rays causes adverse effects on human beings;
- Physicians agree that the benefit derived from diagnostic X-rays far exceeds the possible risks;
- Only limited incidences of accidents due to medical radiation have been reported. No records are available to show that these accidents were the result of improper procedures used by untrained technologists;
- The procedures used can be taught on the job; and
- Quality control measures exist to identify operator error.

## Georgia Occupational Regulation Review Council Members

*Standing members:* William H. Roper, Chairman, Office of Planning and Budget; James Bridges, Department of Agriculture; Andrew Carden, Department of Human Resources; Robert Lenihan, Department of Revenue; William Miller, Secretary of State; Bruce Osborn, Department of Natural Resources; Barry Reid, Office of Consumer Affairs; Martin Wilson, Insurance Commissioner.

*Legislative Appointees:* Representative Ray Moultrie, House of Representatives; Paul Shanor, Senate.

## AD HOC STEERING COMMITTEE ON YOUNG PHYSICIANS SECTION

**S. William Clark, III, M.D.,  
Chairman**

**O**ur Young Physicians Section, while not formally adopted into MAG's Constitution, has nonetheless made considerable strides during the past year in establishing itself as a component of MAG. Chief among these have been initial approval last year by the House of Delegates of a Young Physicians Section, and approval by the MAG Board of Directors of our MAG YPS Bylaws.

Because the 1987 House gave preliminary consent to the creation of a YPS in the House of Delegates, represented by a voting delegate and alternate, the MAG Constitution & Bylaws Committee has drafted the enabling language. It will be brought to the House of Delegates this year for a confirming vote by the Reference Committee on Constitution & Bylaws.

*Recent Activities:* Our Steering Committee has been busy, as evidenced by these achievements:

A) Questionnaire to Young Physician Delegates and Alternates. Last fall Dr. Don Campbell mailed a personal letter to 79 MAG Delegates and Alternates who are young physicians (under 40 or within first five years of practice), asking comments on the feasibility of an MAG YPS. Response was modest (fifteen), but 3/5 of these respondents

stated that MAG *ought* to have a Young Physicians Section, as the House's present emphasis upon county medical society representation did not necessarily ensure adequate voice by young physicians in House activities.

- B) Hospitality to AMA YPS. During the AMA House meeting held in Atlanta last December, the MAG Young Physicians Section arranged, publicized and hosted a very elegant reception for the AMA Young Physicians Section delegates, Saturday night, December 5, in the Presidential Suite of the Peachtree Plaza Hotel. Our function, graciously underwritten by HCA Parkway Medical Center, was one of the highlights of the AMA-YPS meeting, and earned lots of compliments for our Georgia group.
- C) Young Physicians Section luncheon at MAG Leadership Conference. On Saturday, January 23, we held a very successful MAG YPS luncheon at MAG's Leadership Conference, sponsored by Ross Laboratories. Our exchanges, in which MAG's officers and executive staff participated, were informative and fruitful, and a number of young physicians attending have told us of their intention to participate more fully in MAG activities as a result.
- D) Representation in AMA House. Our Georgia YPS has sent a delegate and alternate to last June's and last December's AMA meetings, and we have participated both in the AMA Young Physicians Section meeting as well as in the AMA House. This year, however, AMA will no longer fund a delegate from each state, so we must begin to establish budgetary support from MAG for the future activities of our Section.

Finally, at the upcoming MAG House in Savannah, our Steering



## Unreferred Reports

Committee plans to sponsor a Young Physicians Forum, so all MAG Delegates and Alternates who meet the YPS criteria will have an opportunity to meet, elect a Delegate and Alternate for this year, and discuss issues in general.

All of these efforts reflect the vigorous commitment and unbounded enthusiasm of my fellow Steering Committee members:

James F. Beattie, M.D., Fort Oglethorpe; Donald H. Campbell, M.D., Marietta; Joy A. Maxey, M.D., Atlanta.

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*At the podium, MAG President Jack F. Menendez. To his right is his wife Connie, who contributed much to MAG activities and enhanced the success of her husband's presidency.*



# GIVE YOURSELF A BREAK



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✚ Staff Recruitment and Training – We can help to define your needs, develop an appropriate job description, conduct the search and interview process, and

recommend candidates best suited to your practice environment.

✚ Accounts Receivable Management – We will render bills to your patients and submit claims to third-party payors, either by mail or electronically. Because third-party payors represent a large segment of today's receivables, we continually monitor changes which may impact your practice income such as medical-legal legislation, HCFA, and other health care related government agency mandates.

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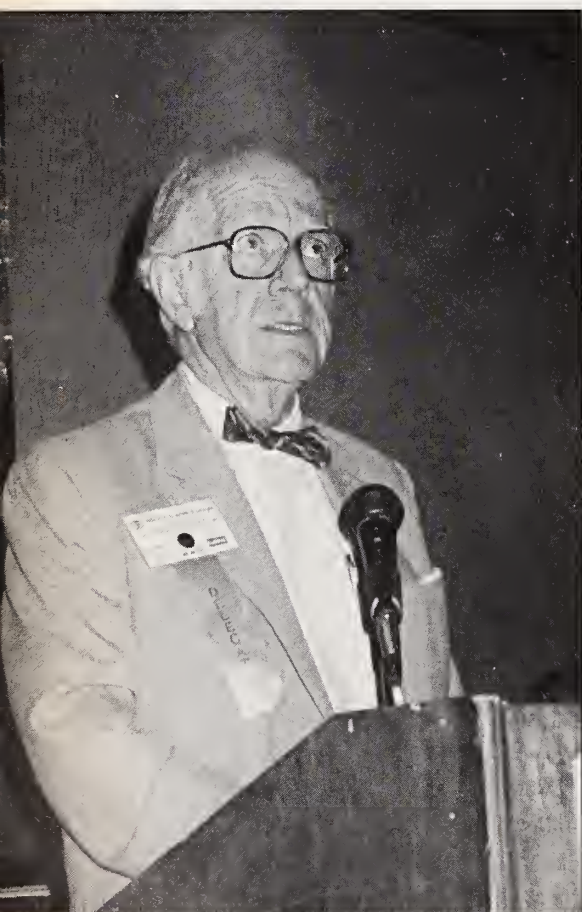
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# Second Session House of Delegates

April 30



*Harrison L. Rogers, M.D., of Atlanta, was the Keynote Speaker at the Second Session of the House. Past President of the AMA in 1985-86, Dr. Rogers urged delegates to strive for unity when addressing medical issues in the political arena.*

**T**he Second Session of the MAG House of Delegates as called to order at 9:00 a.m., Saturday, April 30, 1988, in the Regency Ballrooms of the Hyatt Regency Hotel, Savannah, Georgia, by Speaker James A. Kaufmann, M.D.

## **Introduction of Keynote Speaker**

Speaker Kaufmann introduced the distinguished keynote speaker for the 1988 MAG House of Delegates, Harrison L. Rogers, M.D., Atlanta, Past President of the American Medical Association, 1985-86.

Dr. Rogers, long active in the Medical Association of Georgia, has served as Vice Speaker and Speaker of our House of Delegates, as a member of the Board of Directors, and Chairman of several committees. In June, 1981, Dr. Rogers received MAG's Distinguished Service Award. He has also served as President of the Medical Association of Atlanta. Dr. Rogers was elected Speaker of the AMA House of Delegates in 1981, and prior to that, served as Vice Speaker.

Dr. Rogers received his M.D. degree from Emory University School

of Medicine, interned at Yale, and served his residency at Boston Veterans Administration Hospital. In 1983, he was presented with the Award of Honor by the Emory University Medical Alumni Association.

In addition to being on the active and teaching staffs at Crawford Long and Piedmont Hospitals in Atlanta, Dr. Rogers is a Clinical Assistant Professor in the Department of Surgery at Emory, a diplomate of the American Board of Surgery at Emory, a diplomate of the American Board of Surgery, and a fellow of the American College of Surgeons.

Dr. Rogers is a charter member of the Southeastern Speakers Association, a former member of the American Red Cross Board of Directors, Past President of the Atlanta Clinical Society, and a former member of the Board of Directors and Treasurer of Blue Shield of Georgia/Atlanta. In 1980, he was elected an alumnus member of the Emory Chapter of Alpha Omega Alpha Fraternity.

Following Dr. Rogers' address, Speaker Kaufmann recognized leg-





## PARLIAMENTARIAN

*Serving as parliamentarians were Drs. Charles Langford and Richard Cohen. Richard Green (right at front table) is MAG's legal counsel.*

islators for their public service and public representation with a plaque inscribed: "Certificate of Appreciation awarded for distinguished service as an advocate of quality medical legislation, presented by the Medical Association of Georgia, April 28, 1988."

### **Presentation of Legislators' Certificates of Appreciation**

**Senator Frank Albert**, a member of the powerful Senate Human Resources Committee, proved again in 1988 that he is a key friend of Georgia's physicians and their patients. No matter the non-physician group that was seeking to expand their scope of practice, he stood firm for quality health care. MAG's outstanding President-Elect, Joseph P. Bailey, Jr., M.D., presented the award to Senator Albert.

**Senator Harrill Dawkins**, a key Senator who helped steer the Informed Consent Bill through the Senate in a form that is fair to the state's citizens and physicians. He always is a ready listener to the views of physicians. He also was a leader supporting MAG in the fight

against the so-called "Christmas Tree" amendments to the bill that re-enacted the Composite State Board of Medical Examiners and other health care boards. Dr. Tyson Smith, of Covington, presented the award to Senator Dawkins.

**Senator Tommy Olmstead** proved a freshman Senator can be a highly effective legislator. He became a leader on the Human Resources Committee while working with Georgia's physicians on many health related bills. His hard work and studious attention to detail have made him a health legislation authority that other senators look toward for guidance. Dr. Alva Mayes, a personal friend of Senator Olmstead, presented the award to the Senator.

**Senator Gene Walker** helped Georgia's physicians in 1987 during the tort reform battle. Again in 1988, he was a significant help in limiting physician's liability in several bills before the Senate Special Judiciary Committee. He was also an advocate for a reasonable Informed Consent Bill. Dr. Joy Maxey, a friend of Senator Walker and an AMA Young

Physician representative, presented the award to Senator Walker.

**Representative George Hooks** chaired the Joint Committee given the difficult task of developing a comprehensive AIDS bill which would facilitate the victims of this deadly disease, the health care professionals treating them, and the people of Georgia. He spent hundreds of hours working on the AIDS Bill. Additionally, as a member of the House Health & Ecology Committee and Chairman of its General Health Subcommittee, Representative Hooks was deeply involved in virtually all the legislation of interest to MAG in 1988. Dr. Charles Hollis, Chairman of the Board of Directors for the MAG Mutual Insurance Company, presented the award to Representative Hooks.

### **Lt. Governor Zell Miller Receives Award**

Jack F. Menendez, M.D., Macon, President of the Medical Association of Georgia, introduced Lt. Governor Zell Miller, who has served in the office of Lt. Governor longer than any other Georgian. Zell Miller has



## Second Session-House of Delegates



*Senator Frank Albert, a member of the Georgia Senate's Human Resources Committee, received a Certificate of Appreciation, presented by Dr. Joseph Bailey (left).*



*Senator Tommy Olmstead worked with Georgia's physicians on many health related bills as a member of the Georgia Senate's Human Resources Committee. He was presented with a Certificate of Appreciation by his personal friend, Dr. Alva Mayes (left).*



*Senator Harrill Dawkins (left) was a leader in the Legislature supporting MAG in the fight against the so-called "Christmas Tree" amendments to the bill that re-enacted the Composite State Board of Medical Examiners and other health care boards. He is shown here being presented with MAG's Certificate of Appreciation by Dr. Tyson Smith, of Covington.*



not only continued the commitment he has had throughout his distinguished career to insure all Georgians the highest quality of medical care, he has also continuously demonstrated his long standing friendship to the physicians of Georgia by consulting with the Medical Association of Georgia on issues involving the health and welfare of Georgia's citizens.

When Lt. Governor Miller was a State Senator, he chaired the Senate Health & Welfare Committee, where he sought the opinion of physicians on health care issues that came before that Committee. When he worked for two of our Governors, Zell Miller made sure that the quality of health care for Georgia citizens was a high priority of state government, and he likewise made sure that MAG was significantly involved in developing solutions to Georgia's health care issues.

Three years ago, Zell Miller recognized that the liability crisis was having a severe impact on not only physicians but also small businessmen, city and county governments, non-profit groups, and all Georgia consumers of goods and services. Zell Miller was willing to take the political risks necessary to bring this issue before the General Assembly. Throughout 1986, Lt. Governor Miller traveled across Georgia speaking about the need for tort reform in public forums. The 1987 General Assembly opened with our Lt. Governor having Senate Bills 1 and 2 introduced with enough sponsors to ensure Senate passage.

Thanks, in large part, to Lt. Governor Miller's support of tort reform, a task force was appointed by the Governor to develop an acceptable tort reform package. As a result, a modified version of Zell's legislation became politically stronger as a joint proposal by the Governor and Lieutenant Governor.

The 1988 Legislative Session was an extremely active one for MAG and its members. Throughout the Session, Lt. Governor Miller contin-



*Senator Gene Walker was a significant help to the MAG in 1988 in limiting physicians' liability in several bills before the Senate Special Judiciary Committee. Dr. Joy Maxey presented him with MAG's Certificate of Appreciation.*



*Representative George Hooks chaired the Joint Committee which developed a comprehensive AIDS bill. As a member of the House Health & Ecology Committee and Chairman of its General Health Subcommittee, he was intensely involved in virtually all legislative matters of interest to MAG. Dr. Charles Hollis (left), of Albany, presented Representative Hooks with MAG's Certificate of Appreciation.*



## Second Session-House of Delegates

ued his long tradition of being a true friend of Georgia's physicians and their patients. He continued to advocate quality health care for the citizens of Georgia, and he continued the close working relationship with MAG that has been so helpful for so many years.

For these and other pertinent reasons, we are presenting our Lieutenant Governor with a special MAG award, inscribed "Legislative Service Award, presented to Zell Miller, Lieutenant Governor, in recognition of his exemplary leadership and invaluable support of quality health care legislation on behalf of the citizens of Georgia. Awarded by the Medical Association of Georgia, Annual Session 1988."

### Credentials Committee Verifies Presence of Quorum

Following Lt. Governor Zell Miller's brief comments to the 1988 MAG House of Delegates, the Speaker called for a report from the Credentials Committee which was given by Milton I. Johnson, M.D., Macon. Dr. Johnson reported that 137 delegates and 14 alternate delegates were present, representing 42 component county medical societies. As provided in Chapter III, Section 3 of the Bylaws, a quorum was present.

### Announcement of Election Reports

Speaker Kaufmann announced that the results of the 1988 elections are as follows:

President-Elect: Joe L. Nettles, M.D., Savannah; Second Vice President: Bob G. Lanier, M.D., Atlanta; AMA Delegates: Carson B. Burgstiner, M.D., Savannah; S. William Clark, Jr., M.D., Waycross; Joe C. Stubbs, M.D., Valdosta; AMA Alternate Delegates: E. M. ("Mac") Molnar, M.D., Columbus; Beverly B. Sanders, M.D., Macon; Ellis B. Keener, M.D., Gainesville; Jack F. Menendez, M.D., Macon; Richard W. Cohen, M.D., Austell; MAG Delegate to AMA Young Physicians

Section: Spurgeon Wm. Clark, III, M.D., Waycross; MAG Alternate Delegate to AMA Young Physicians Section: Joy A. Maxey, M.D., Atlanta

### Adoption of Special Resolution By the 1988 MAG House of Delegates

Speaker Kaufmann requested unanimous consent to admit a late

therefore, be it

RESOLVED, that Michael Fowler be commended for his outstanding stewardship and management of MAG's operations during 1987-88 as its Executive Director."

The House of Delegates unanimously passed the Resolution and gave Michael Fowler, MAG Executive Director, a standing ovation.



*Lt. Governor Zell Miller continued his support of Georgia physicians and their patients throughout the 1988 General Assembly. Dr. Jack Menendez presented him with a special MAG award, the Legislative Service Award, in recognition of the Lt. Governor's exemplary leadership and invaluable support of quality health care legislation on behalf of the citizens of Georgia.*

resolution to the House. With consent of the House, Speaker Kaufmann introduced John D. Watson, Jr., M.D. of Columbus, Immediate Past President of the Medical Association of Georgia, to present a Resolution to the House inscribed:

"Whereas, the operation of the Medical Association of Georgia is looked upon with high regard and respect throughout the nation;



### REFERENCE COMMITTEE REPORTS

#### New Business

By acclamation, the House extended its appreciation to Speaker Kaufmann and Vice Speaker Raines for their expertise in presiding over the activities of the MAG House of Delegates and to the MAG staff for their efficiency in coordinating all the functions required for a successful meeting.

#### Recess

Speaker Kaufmann recessed the Second Session of the House of Delegates at 4:00 p.m., with the House to be called back to order at 6:30 p.m. in the Verelst-Percival-Vernon Rooms, for the installation of officers and final adjournment.

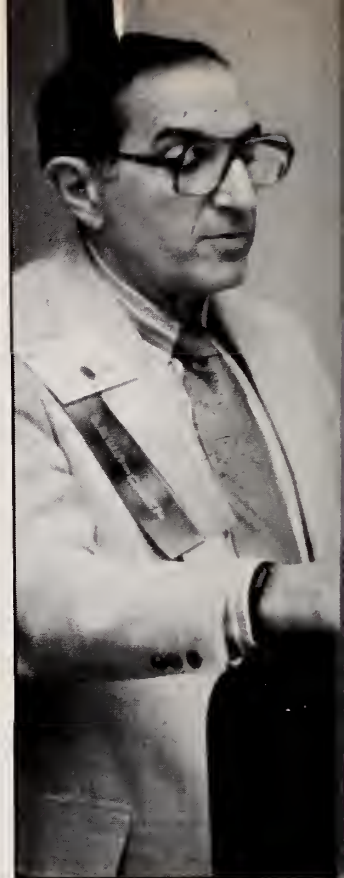


*The Lt. Governor, Senators, Representatives and the physicians who presented them with MAG awards are shown here as a group. MAG is indebted to these political leaders for their continued support and cooperation to better serve the health care needs of Georgians.*



# Report

## Reference Committee



### PRESIDENT'S REPORT

**Jack F. Menendez, M.D.,  
President**

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**T**he following physicians were members of Reference Committee A: Luther M. Thomas, Jr., Chairman, Richmond; Carl V. Hancock, Jr., Vice Chairman, Dougherty; Phillip N. Bannister, Gwinnet-Forsyth; Rene A. Morell, Cobb; Richard C. Mattison, DeKalb; Dent W. Purcell, Georgia Medical Society; William H. Whaley, Medical Association of Atlanta; Kenneth L. Goldman, Muscogee; Charles A. Lanford, Bibb; and David D. Tanner, Medical Association of Atlanta.

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*Referred to: Rec. 1, 2 (a, b), 3, 4, 5 — Reference Committee D; Rec. 2 (c, d) — Reference Committee C; Rec. 6 — Reference Committee A; Rec. 7 — Reference Committee C.*

**“M**ay you live in interesting times” is purported to be a Chinese curse. Curse or not, this has been an interesting year for our Medical Association and for me as President. Our efforts in the areas of AIDS education, public relations, legislation, the Scientific Session, and in many other areas, have been successful thanks to hard work by many of our members and our staff. We weathered a major staff change, had the AMA in Atlanta for their Interim Meeting for the first time in 90 years, and handled other equilibrium-shaking events with reasonably good results. It has indeed been an interesting year. I am privileged to have been President during this year.

During my twenty-plus years as a delegate, my fourteen years on the Board of Directors and the Executive Committee, and this year as President, I have noted some problems with MAG structure and functions. I wish to share those concerns with you and propose some solutions to these problems.

The delegates of MAG are the backbone of the Association. The House of Delegates is charged in the Constitution Article V, Section 2 as, . . . “the legislative body of the Association and it shall transact all business for the Association not otherwise specifically provided for in this Constitution & Bylaws.” At present the delegates meet for two days, in the Spring, and try to project the course of the Association for a full year. We find ourselves setting a medical legislative course for the General Assembly that will meet some eight months later. The same is true for the budgetary process, medical practice concerns, public relations, etc. A second house meeting per year would give the delegates more involvement in the decision-making process. We will all benefit from a wider interchange of ideas and opinions. It





*At the podium, MAG President Jack Menendez addresses members of Reference Committee A.*

would make sense to have two House of Delegates meetings — one in the spring and one in November. The spring meeting could focus more on national legislative issues, and the fall meeting more on state issues, thus bringing the House of Delegates to the forefront of the decision-making process.

Another concern is that some things are not working well in our organizational structure. Our councils do not function as well as they could. Certain important committees do not function well, if at all. This could be significantly improved by assigning some of these functions to specific officers.

There are four officers on the Executive Committee who have no specific functions — the Second Vice-President, First Vice-President, President-Elect, and Immediate Past President. It would make sense for these officers to perform some of these functions. The Second Vice-President can chair the Membership Committee. The First Vice-President can be in charge of the Ad Hoc Committees, now numbering twelve. This is a “loose end” in MAG structure. Ad Hoc Committees are formed and no one pres-

ently advises on their need for continued service or for sunsetting.

The Legislative Committee needs to be more active, involving more members by geography and specialty. This year there were five specialty PAC's at the Capitol. An active Legislative Committee would blunt the thrust toward the proliferation of specialty PAC's. The President-Elect should be Vice Chairman of the Legislative Committee, with principal responsibility for coordinating staff activity in developing specialty participation and working with physicians, Auxilians and legislators at the local level. It is especially important that the President-Elect perform this function. It prepares him for one of his roles, that of legislative spokesman for MAG. The overall Legislative Council should continue to be chaired by Dr. James Kaufmann. In this way MAG can continue to benefit from his unique abilities and knowledge of the State Legislature.

As for the Immediate Past President, I tried to find a nice easy job for him since I will be *it*. In truth, the best job for him is to plan legislative events such as the Legislative Seminar, the Doctor-of-the-

Day and P.I.P. programs. The Legislative Seminar could be tied in to the fall House (perhaps also the Scientific Session). The Immediate Past President has the legislative and AMA contacts to make these functions work better. The Immediate Past President should also sit on the Legislative Committee as Vice Chairman of legislative events.

Another concern is the lack of coordination between MAG and AMA. We hear one report yearly from our AMA delegation, at the June Board of Directors meeting. The MAG House of Delegates does not address important national legislative concerns such as Medicare regulations, federal initiatives in the tort reform area, and others. This should be at the spring meeting of MAG which is *prior* to the June meeting of AMA. The Chairman of the AMA delegation should sit on the MAG Executive Committee as a voting member.

With two meetings of the House of Delegates per year the Executive Committee and Board of Directors can meet less.

The Executive Committee would function better, in my opinion, if it met every 6 weeks rather than



monthly. The Board of Directors would function more effectively with two meetings a year, halfway between the House meetings. It is unnecessary for the Executive Committee and the Board of Directors to meet just prior to the House meetings since the House actions supersede both the Board and Executive Committee actions.

Some of these changes will require Bylaws changes and some can be implemented directly by the House (see Recommendations below).

I would like to address two additional projects for MAG to consider. If we are to avoid mandatory assignment, we must assume the role of Senior Citizen Advocate. This has been done in different ways in the State of Connecticut, and the cities of Cleveland, Ohio and San Antonio, Texas. We need to implement such a policy in Georgia, after thorough investigation.

We also need to pursue ever more vigorously the removal of professional liability from the tort area. There is a great deal of activity in this area across the nation.

A legislative package needs to be prepared as soon as possible.

### Recommendations

1. That the MAG House of Delegates meet twice a year.
2. That, at the President's discretion:
  - a. The Second Vice-President chair the Membership Committee;
  - b. The First Vice-President supervise all Ad Hoc Committees;
  - c. The President-Elect be Vice Chairman of the Legislative Committee and in charge of legislative education; and
  - d. The Immediate Past President be Vice Chairman of the Legislative Committee in charge of legislative events and *plan* the MAG legislative events, specifically the Legislative Seminar, the P.I.P. program, and the Doctor-of-the-Day Program.

3. That the Committee of the AMA delegation sit on the Executive Committee.

4. That the Executive Committee meet every six weeks, or by call of the President, but not prior to meetings of the House of Delegates.\*

5. That the Board of Directors meet twice a year, between meetings of the House of Delegates.\*

6. That a senior Citizen Advocacy Program be presented to the next House of Delegates meeting.

7. That a proposal for legislative action, removing professional liability from the courts be presented to the next House of Delegates meeting.

\*Require Bylaws change, Fiscal Note: \$10,000.

### House Action

*Recommendation 6:* Adopted as amended to read: "That a senior Citizen Advocacy Program be most expeditiously developed, and be reported no later than to the next Board of Directors meeting."

## FIRST VICE PRESIDENT

**Joe L. Nettles, M.D.**

*Referred to: Rec. 1 — Reference Committee C; Rec. 2 — Reference Committee D; Rec. 3 — Reference Committee A.*

**I**t has been my pleasure to serve this year as First Vice President under the leadership of our President, Jack Menendez. Like all MAG officers, I recognize that our profession faces problems that we need to address.

The number one problem of the physicians of Georgia is affordable liability insurance. At this time, Georgia is supposedly number four, after New York, Florida and Illinois,

in average premium cost. After this year's passage of Informed Consent Law, we may even go higher despite the fine efforts of Richard Greene in making the statute as reasonable as possible. Four of nineteen orthopedic surgeons in Savannah, all under the age of 60, no longer operate. A higher percentage of OB-GYN specialists are giving up deliveries, and the rising incidence of Caesarean sections likely reflects defensive medicine. Despite no lawsuits, my annual premium as an orthopedic surgeon has risen from \$6,178 in 1983 to \$54,326 in 1988. (Coverage was expanded from two million to three million in 1986.) At the present rate of increase, the premium would soon exceed gross income and, of course, this is what is causing people to give up portions or all of their practice. My policy is with MAG Mutual and reflects every discount that is available for risk management seminars and such. Evidently St. Paul's premiums have escalated at a more alarming rate, and they are no longer writing new policies.

What can be done? Thanks to a mandatory dues assessment, the Medical Association of Georgia now has in excess of one-half million dollars in a war chest toward the liability crisis. Hopefully, the reforms passed in last year's legislative campaign are going to be reflected in future statistics, but if not, we cannot hold out much longer. Even if we can afford the premium, the trauma of a malpractice suit or threat of litigation takes the joy out of practicing medicine.

The situation in Florida recently became so critical that a special legislative session was called. The President of the Florida Medical Association described the result as a 4 on a scale of 1-10. The Florida Medical Association is now busily obtaining signatures for a constitutional amendment on the November ballot limiting to \$100,000 the amount that can be paid for non-economic damages in all liability



disputes.

Another approach is to place a special tax or surcharge on all surgical procedures to cover the damages in a mal-occurrence, as set forth by a panel similar to Workman's Compensation. This has recently been accomplished statewide in Virginia in regard to birth-related neurological injuries, and nationwide in regard to DPT vaccine. Otherwise, the dwindling number of doctors who can still afford to practice will eventually be overwhelmed by the added risk load.

Therefore, I would like to propose the appended recommendations in order that the Medical Association of Georgia immediately launch a full-scale campaign to halt the escalating and prohibitive costs of liability insurance.

I recognize that these following recommendations set ambitious goals for us. But I believe that our officers, members and staff, through coordinated action, can frequently achieve the difficult. We certainly have an obligation to our profession and our patients to see that this is done.

### Recommendations

1. Further legislative efforts should be pursued by MAG to obtain a cap on non-economic damages, even if this has to be done through other than traditional legislative reform in a lawyer-packed legislature.

2. A statewide or nationwide surcharge, or added tax on all or high-risk surgical procedures should be implemented to cover mal-occurrences.

3. The MAG should continue to work hard with MAG Mutual and any other insurance carrier to make adequate liability coverage affordable to every physician.

### House Action

Adopted Recommendation 3.

See Report of Reference Committee C for House Action on Rec-

ommendation 1 and Report of Reference Committee D for House Action on Recommendation 2.

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## SECRETARY

Ralph A. Tillman, M.D.

**H**aving less interest in where we have been than where we are going, I wish to devote this report to the future and what, if anything, we can do to alter the course of medicine. Every year brings forth efforts on the part of many that results in progressive erosion of the traditional doctor-patient relationship. Attempts at thwarting these efforts appear to be minimally effective, and frequently result in only delaying renewed and more onerous efforts. It is both incredible and saddening that these attacks come from state and federal levels as well as from some elements of the private sector that should be our closest allies.

There are many factors that reduce the genuine pleasure, satisfaction, and sense of accomplishment that comes from caring for those who need our services. Perhaps, nothing more devastating has come from the minds of men (used loosely, to refer to governmental bureaucrats) than the onerous, ambiguous rules from HCFA in our management of Medicare beneficiaries. My heart bleeds for those of you whose practice is predominantly Medicare.

What can we do to turn things around — to preserve some freedom for both physician and patient in providing the highest quality of care for all citizens, at a cost that is affordable and reasonable, yet at a level that physicians can expect to make a comfortable living? We must find a way to both *gain* and *deserve* more active and aggressive support from the public — all of whom seek our services at some

time in their lives.

Permit me to enumerate some of the things I feel should take top priority toward making some inroads to the above — first, and foremost, we must always be the patients' advocate. We must exhibit more *compassion* and less callousness, show more *concern* and *interest* in the patient and his/her family, be readily *available*, *responsive*, *informative* and *willing to listen!* We must be willing to individually and as an *involved* member of organized medicine to serve on peer review committees, to be part of due process procedures to properly reprimand, suspend, and revoke licenses of those physicians whose actions so dictate.

Plato has been quoted as saying, "He who thinks he is too smart to become involved in politics, frequently finds himself being governed by those much dumber" (perhaps, not verbatim; and the opposite gender fits equally well). Never has it been more necessary for us to be involved in the political process — from being candidates ourselves to selecting and supporting candidates throughout the election process and term of that office. Only then can we expect to find more friendly faces and response from those at the state house and in Washington. Through well-designed planning and proper dialogue we can and must solicit support in our efforts from the elderly, from those in Mom and Pop industries, big business executives, the "grass roots" labor force, and those in education. With 75% participation of the physicians and spouses in this state and nation, we could readily become a potent force with recognition we probably have never had! What would all this require? *Involvement*, *Commitment*, and *Dedication* — a burning desire and willingness to participate with time and money! The Medical Association of Georgia and the American Medical Association have the means wherein we could do all of the above



## Membership Comparison

	1987	1986	1985	1984	1983
Active	5351	5208	5056	4879	4813
Active Resident	538	376	357	125	86
Affiliate	7	7	7	7	9
Associate	64	58	62	53	51
DE-1 (financial hardship/illness)	58	54	48	48	50
DE-2 (post-grad training)	2	2	2	3	3
DE-4 (temporary military)	2	2	2	4	4
DE-5 (life)	325	262	257	264	247
DE-7 (over 70)	35	89	87	74	116
Retired	325	304	241	197	167
Service	52	56	62	63	59
Student	141	93	50	6	13
	6900	6511	6231	5723	5618
AMA Membership*	3403	3289	3416	3776	3719

\* The above AMA membership figures reflect only those AMA members who pay AMA dues via MAG.

— if the members of those organizations so desire!

### Recommendations

1. That the Membership Committee be changed to the *Membership Expansion and Involvement Committee*;

2. That this Committee be chaired by the President-Elect and include broad-based representation from all sections of this state and from all or most specialty societies; and

3. That this Committee be charged with establishing a 3 year plan (1988-90) toward gaining maximum membership and participation in MAG on the local, state and national level.

### House Action

Recommendation 1 — Adopted.

Recommendation 2 — *Adopted as amended* to read: "That this Committee be chaired by an officer, other than the Secretary, to be appointed by the President, and include broad-based representation from all sections of this state and from all or most specialty societies."

Recommendation 3 — Adopted.

## SPEAKER

James A. Kaufmann, M.D.

For this 134th Annual Session of the Medical Association of Georgia House of Delegates, Dr. Raines and I continue to strive to insure that the House offers an opportunity for *every member* of the Association to express his or her viewpoints.

This spring we have once again made liberal use of the *Journal of the Medical Association of Georgia* and the *MAG Newsletter*. We have encouraged non-delegate members to participate in our House proceedings, especially at Reference Committee hearings. And for our Reference Committees we have drawn members from across the state, attempting the most democratic representation of our county medical societies.

The House of Delegates is MAG's legislative body, responsible for shaping the policies which guide our Association from year to year. We cannot do so, however, without a large number of resolutions or recommendations to bring various topics before the House for discussion. We rely on our Committees for recommendations, and our Del-

egates or County Societies for resolutions, but sometimes very significant topics are not covered by these submissions. I believe the Annual Session Committee and the President's Cabinet, whose members oversee the work of our Association's committees, could address this problem, and so have proposed a course of action below.

The Annual Session Committee will continue its work in helping to make our upcoming House meetings as responsive to the needs of our membership as we can.

### Recommendation

That the MAG President's Cabinet hold a meeting with the Annual Session Committee thirty days before next year's House of Delegates, for the purpose of reviewing overall MAG Committee activities and ensuring that adequate resolutions or recommendations on appropriate subjects will be submitted to the House.

### House Action

Adopted with commendation.

## VICE CHAIRMAN OF THE BOARD OF DIRECTORS

Frank F. Middleton, III, M.D.

I have benefited immensely from my service during the past year as Vice-Chairman of the Board, and hope that I have contributed to its discussions of the important issues before us.

I believe that our Board of Directors fulfills a very significant role in ensuring, at our quarterly meetings, that MAG's membership across the state has ample opportunity to communicate its concerns and to be educated on current professional issues. This presentation and communication works best when



there is strong liaison between each Director and the physicians in his locality, whom he represents.

In order to foster this liaison, I wish to remind my colleagues on the Board of a passage in the Medical Association of Georgia Bylaws, pertaining to the duties of Board members:

*Chapter V. Board of Directors, Section 8. Duties of Directors and Alternate Directors. (page 14) Each Director shall be organizer, peace-maker, and censor for the district represented by the respective Director. The Director shall visit each county in the respective district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of, and to aid in the betterment of, the component societies in that district. The Director shall make an annual report at the Annual Session of the House of Delegates, listing all eligible physicians in the respective district who are not members of a component society and describe the work and the condition of the profession of each county in that district. The Alternate Director shall assist the Director in the performance of duties.*

While I believe that every Director in pursuing these duties generally, I am especially interested in encouraging my Board colleagues to attempt to visit each county society in their respective districts at least once a year for the purpose of "inquiring into the condition of the profession, and to keep in touch with the activities of, and to aid in the betterment of, the component societies in that district." I have therefore added the recommendation below to address this goal.

Thank you for the privilege of allowing me to serve.

## Recommendation

That members of the MAG Board

of Directors be encouraged to visit each county society in his or her respective district at least once a year for the purpose of communicating Board actions, responding to members' concerns, and discussing issues of interest to the profession in general.

## House Action

Adopted.

## MAG MUTUAL INSURANCE COMPANY

**Charles D. Hollis, Jr., M.D.**

**1** 1987 has been MAG Mutual's most successful year in terms of improving policyholder benefits, strengthening the company's financial condition and new policy features. Several innovative programs are being implemented which clearly demonstrate MAG Mutual's commitment to Georgia physicians. These new benefits include:

- A 5 percent refund of 1987 premiums for renewals after 4/1/88.
- L.E.A.D. Program discount for physicians without paid losses.
- Prior Acts coverage.
- New benefits to help pay for tail coverage at retirement.
- Seminars for MAG Mutual policyholders about Georgia's new informed consent law.

The Company is exploring the possibility of forming a captive reinsurer in 1988 in conjunction with other physician-owned professional liability insurers. If this captive reinsurer is formed, it will primarily provide reinsurance to MAG Mutual and these other insurers in lieu of portions of the reinsurance presently provided by commercial reinsurers. The Company proposes to make a substantial capital investment in this proposed captive

reinsurer. We believe this new source of reinsurance will help reduce the cost of higher limits of coverage to our policyholders and will strengthen the financial position of the Company.

There was continued growth in market for new insureds. We added 515 new policyholders, but because of the usual attrition rate of about 6 percent due to death, retirement and transfer, we realized a net increase of about 300 policyholders. Because of MAG Mutual's strict underwriting requirements, the acceptance rate of new applicants continues to be around 80 percent. An attachment shows MAG Mutual's results for 1986, 1987 and the first quarter of 1988.

St. Paul continues its moratorium on new business and six months policies. It took two rate increases during 1987 and MAG Mutual one, making our filed rates about 15 percent less on the average than St. Paul. Of course, our discounts make the difference even greater.

In September MAG Mutual moved to its new offices to Eight Piedmont Center, Suite 600. This has proved to be a very wise choice. The space is much more adequate and the financial terms were extremely favorable.

In October of 1987, the Executive Committee and Executive staff held a weekend planning session. The goals and mission of MAG Mutual were reaffirmed. The primary mission of the Company continues, as always, to be a stable liability insurance market for physicians in Georgia. Other commitments were to work toward improving the quality of medical care throughout Georgia and to work toward improvement in the medical-legal climate in the State.

Several innovative programs are in process. The slogan, "MAG Mutual is Different," is to be the byword for the Company and its operations. The Company is proposing a program to discount insurance premiums for anesthesiologists.



ogists based on sound loss prevention methods. Participation in the program is voluntary. Starting in February, MAG Mutual began offering prior acts coverage, making it possible for a physician to switch to MAG Mutual without buying expensive tail coverage from his/her current carrier. We feel this is a significant expansion in features in the coverage to doctors.

We will continue to work closely with and maintain a liaison with the Medical Association of Georgia. The two organizations can be mutually supportive in many ways. This has been demonstrated in the past and we expect it to be an even more effective alliance in the future. The Company continues to encourage all of its insureds to be members of the Medical Association of Georgia by offering significant financial incentives. The Company is totally convinced that a physician active in organized medicine is a better insured.

Attached is a handout which shows the trend in claims frequency comparing St. Paul in Georgia and MAG Mutual. The preliminary trend is encouraging. We believe there is a "light at the end of the tunnel." Another handout compares rates for \$1,000,000 coverage between St. Paul and MAG Mutual. These are the rates in effect for both St. Paul and MAG Mutual in April, 1988.

MAG Mutual's discount programs will have a significant impact upon the total cost of insurance for our policyholders. The discount programs include the Loss Prevention Seminar discount, the group discounts, the discount for deductible policies, new doctor discounts and the LEAD discount.

MAG Mutual has been actively assisting MAG in its lobbying efforts regarding an informed consent bill. Our Director of Loss Prevention and MAG Mutual defense attorneys have collaborated with MAG's staff to draft language that will be more fa-

vorable to physicians than the bills originally introduced. MAG Mutual will begin offering seminars about the new informed consent law to its policyholders.

We have reviewed with great interest the AMA's proposed alternative to solving the professional liability program. This proposal calls for drastic changes in the current liability system. We are now preparing a thorough written analysis of this proposal and will submit it to MAG shortly.

## Recommendation

After reviewing the AMA's proposal, we conclude that Georgia physicians would pay higher professional liability premiums under the AMA's proposed system than under the current litigation system. We, therefore, recommend that Georgia not be one of the trial states under the AMA's proposed plan.

## House Action

Adopted.

## The MAG Mutual Difference

1. 5 percent refund of 1987 premium for renewals after 4/1/88.
  2. L.E.A.D. Program discount beginning 5/1/88 averaging 6 percent, for physicians without paid losses.
  3. "Prior Acts" coverage; applications are coming in at a good pace; loss histories look clean.
  4. Rates average 22 percent lower than St. Paul.
  5. Earn credits towards tail at retirement — beginning at age 60, earn 20 percent credit per year. Enables physicians to retire early at reduced cost of tail.
  6. \$1/3 million available, and mandatory for physicians buying excess limits.
  7. 1987 Financial results: (Increased surplus, strengthened balance sheet).
  8. Pre-funding the tail 3, 4, or 5 years prior to retirement.
  9. Lowering classification and premium (2 options).
- Pay higher premium for 2 years
  - Buy out portion of tail for high risk class

## ATTACHMENT TO MAG MUTUAL INSURANCE COMPANY'S REPORT

### MAG Mutual Financial Results

	12/31/86	12/31/87 Estimate	3/31/87
Written Premium	\$38.8 Mil	\$55 Mil	\$18.8 Mil
Policyholders	3,045	3,344	3,400
Expense Ratio	5.4%	6.9%	7.9%
Policyholders' Surplus	\$6.7 Mil	\$10.7 Mil	\$11.5 Mil
Total Admitted Assets	\$66.1 Mil	\$111 Mil	\$122 Mil
Invested Assets	\$60.1 Mil	\$94 Mil	\$96 Mil
Rate of Return on Investments		8.2%	7.9%
Total Claims Reported		2,395	2,500
Claims Closed		1,470	1,500
Claims Open		958	900
Claims Closed With Indemnity Payment		184	200
Claims Paid (Loss and LAE), Since Inception		\$35.9 Mil	\$40.1 Mil
Claims Pending, Reserved Since Inception		\$79.5 Mil	\$89.5 Mil



Class	Specialty	Total Number of Certificates Required Per Physician	Discounted St. Paul \$1M/\$1M Mature	Manual MAG Mutual \$1M/\$1M Mature	Average 8% Discounted MAG Mutual \$1M/\$1M Mature	Discount % Difference
5	Psychiatry	1	\$ 6,496	\$ 4,521	\$ 4,159	56%
1	Family Practice, Internal Medicine (No surgery, no invasive procedures), Pediatrics	1	\$ 6,496	\$ 5,898	\$ 5,426	20%
2	Family Practice (minor surgery), Internal Medicine (some invasive procedures), Radiology (non-invasive)	2	\$ 9,523	\$ 8,847	\$ 8,139	17%
3	Ophthalmology, Radiology (invasive), Cardiology (Catheterizations, All Laser Therapy), Urology, Family Practice	3	\$12,555	\$11,796	\$10,852	16%
4	Emergency Medicine	4	\$16,801	\$15,847	\$14,579	15%
5A	Anesthesiology	6	\$27,845	\$25,292	\$23,269	20%
5	General Surgery, Plastic Surgery, Otolaryngology (Surgery), Gynecology (Surgery)	6	\$31,293	\$28,308	\$26,043	20%
6	Orthopedics, Vascular Surgery, Thoracic Surgery, Cardio-thoracic Surgery	8	\$41,579	\$37,549	\$34,545	20%
7	Obstetrics	10	\$51,845	\$46,791	\$43,048	20%
8	Neurosurgery	13	\$66,524	\$58,855	\$54,147	23%
					Average	22%

Note: The various MAG Mutual discount programs average 8.6 percent, making the differential between MAG Mutual and St. Paul 23.6 percent for 85 percent of our insureds.

## Claims — Highlights of 1987

1. The Claims Department added three (3) new representatives to their staff: Ed Womack, David Forstner and Paula Snipes.

2. Files opened in 1987: 548; Total Since Inception: 2,395.

3. Files closed in 1987: 474; Total Since Inception: 1,470.

1987

58 Closed with Indemnity	(12%)
268 Closed with LAE	(57%)
148 Closed with No Pay	(31%)

474

4. Loss Payments in 1987, \$10,897,992.05; LAE Payments in 1987, \$3,604,218.15; Total, \$14,502,210.20.

5. Lawsuits Received in 1985: 186; Lawsuits Received in 1986: 162; Lawsuits Received in 1987: 100.

6. Number of Trials in 1987: 23; Wins, 19; Lost, 4 (83%). Trials Since Inception: 53; Wins, 44; Lost, 9 (3 in appeal).

7. Percentage of Cases Won: 83% if 3 appeals are unsuccessful; 89% if we prevail on all 3 appeals.

## SPECIAL REPORT 2 — SUPPLEMENTAL MAG Mutual Insurance Company

**Analysis of AMA Fault-Based, Administrative Alternative to the Civil Justice System for Adjudicating Medical Professional Liability.**

Let me preface my remarks by pointing out that the AMA proposal is good for the financial growth and expansion of MAG Mutual Insurance Company and the



other medical liability insurers. We believe that it will generate sharply higher revenues for MAG Mutual as premiums climb. We will have to greatly expand employment in the Claims Department in order to complete the investigation and coordinate the defense of many more claims in a much shorter time frame. Likewise, employment in the Underwriting and Loss Prevention Departments will also increase to fulfill the AMA mandated additional underwriting, reporting and loss prevention duties. The cadre of defense lawyers will be expanded to handle the increased volume of claims.

However, the AMA proposal is not good for physicians in Georgia and, therefore, MAG Mutual respectfully opposes it. Our opposition to the AMA proposal is not based on the adage "if it ain't broke, don't fix it" because clearly the rapid escalation of medical liability premiums has caused a severe economic burden for many physicians and a true crisis of affordability and availability for certain medical specialties. Something needs to be done. In addition to meaningful tort law reform to level the playing field, the real solution to the insurance crisis lies in effective loss prevention which changes patient expectations and reduces the frequency and severity of losses. However, these subjects are beyond the scope of this report.

Rather our opposition is based upon the proverb set forth at Johns Hopkins, "Primum non nocere"; First, do no harm. In other words, in trying to heal the patient, don't make things worse. We believe the AMA proposal will make things much worse for Georgia physicians.

Finally, the sociological issue of whether the AMA proposal is good for society is referred to others for debate. This report is limited to analyzing the insurance premium and regulatory impact of the AMA proposal on physicians practicing medicine in the State of Georgia.

### Executive Summary

The AMA believes that its administrative agency alternative is designed to respond to what it sees as the three main problems with the current judicial system: (1) the barrier to access to the courts created by the costs of litigation, (2) the inconsistent and increasingly large jury awards, and (3) the high cost of the adjudication process.

In analyzing its own proposal, the AMA concludes:

"The administrative model for dispute resolution of medical liability claims provides significant incentives for parties to pursue claims and a significant likelihood of being compensated in a fair, cost-effective and expeditious fashion."

We believe that the AMA is absolutely correct in its assessment of the impact of its proposal. Unfortunately, this result will be to drive physicians' insurance premiums very much higher — doubling or perhaps tripling premiums as frequency explodes while severity does not decline. The administrative cost savings are modest and won't begin to offset the increase in frequency.

The AMA mistakenly believes that awards for "pain and suffering" and large jumbo jury verdicts are the cause of high insurance premiums. While the large losses are a factor and are worrisome because they are increasing, they are not the main cause of high premiums. In fact actuaries truncate all losses at \$100,000 in rate making for the specific reason of keeping the large losses from distorting premiums. In the March 7, 1988 issue of *Medical Economics*, the article entitled, "Can the AMA Sell its Own Brand of Malpractice Reform?", Barbara Reynolds, Senior Communications Manager, St. Paul Fire and Marine Insurance Company discusses whether frequency or severity is the problem. She states:

"Much of the malpractice problem has been caused by the increasing number of claims being filed in recent years. . . . Though they do affect total costs, the huge awards we all read about are rare. . . .

While the AMA arbitration proposal guarantees much higher claim frequency, MAG Mutual does not expect it to lower loss severity. Two years ago the Fulton County, Georgia, Superior Court began a non-binding arbitration program. In just the first two years, there have been at least three awards approaching or exceeding one million dollars each.

The AMA's proposal limits pain and suffering and punitive damages (all non-economic damages) to one-half the state average annual wage multiplied by the injured party's life expectancy, but not less than 15 years. Its maximum award for pain and suffering is capped at about \$700,000; the maximum is about \$150,000. In Georgia these amounts are much higher than the current average pain and suffering award of \$71,141 we incur. And it has been accepted by those studying tort reform that caps on non-economic damages have little impact when the amount is above \$250,000.

Furthermore, the proposal provides unlimited recovery for economic or special damages; i.e. out-of-pocket expenses, lost past and future wages, etc. Unlimited recovery of economic loss is the principal reason why claim severity will not drop under the proposal. By far, the largest elements of even the rare jumbo awards in Georgia are lost future wages, future medical expenses and other economic loss; not pain and suffering. Yes, there are cases which have been the exception, but we can count them on one hand.

It is the recommendation of MAG Mutual that the Medical Association of Georgia refrain from volun-



teering to be a pilot state for the AMA proposal and that it consider voicing formal opposition to the AMA pursuing its proposal further without substantial modification to correct the proposal's current grave shortcomings.

### Analysis of AMA Rationale

According to the AMA, it believes that:

- A) the current judicial system for determining professional liability does not compensate a significant number of patients who have been injured by medical negligence.
- B) the current tort system, which relies heavily upon juries is not optimally suited for resolving medical negligence issues.

The observations are true, but they have had the effect of restraining the growth in premiums, not escalating them.

The AMA's proposed treatment for curing high premiums is wrong for a very simple reason. It has misdiagnosed the illness. Essentially the AMA proposal is based upon three assumptions which it believes are supported by independent studies:

1. Of all medical liability awards of \$100,000 or more, 80% of the award is for pain and suffering (Rand Corporation).
2. 57% of all medical liability claims are without merit (Government Accounting Office).
3. 57% of premiums paid by physicians are spent on the settlement and litigation process; i.e. on plaintiff and defense attorney's fees, expert witnesses, and court costs (Rand Corporation).

In order to test the validity of the AMA assumptions, MAG Mutual conducted a closed claimed study of 1,565 claims closed between June 1, 1982 and April 1, 1988. As will be substantiated later in this report, we found that the assumption that 80% of large losses are for pain and suffering and that 57% of all claims

are without merit is simply not true in Georgia. I seriously doubt whether either assumption is valid in any jurisdiction except, perhaps, Dade and Broward Counties, Florida. The third AMA assumption we found to be correct; more than half the premium is consumed in investigating claims and in attorney's fees for both the plaintiff and the defendant.

### AMA Proposal

In order that the reader may better understand our analysis and observations, I need to briefly explain the proposal and how it would work.

#### A. The Structure

The AMA proposal is that the current civil justice system for adjudicating medical negligence be replaced with a state administrative agency. The agency could either be a modification of the current Composite State Board or a new agency.

Membership on the Board of the agency would be full-time for at least a five year term. Reappointments are possible. Members would be appointed by the governor from a list of nominees selected by a citizens nominating committee — and approved by the legislature. The AMA recommends a seven person Board of which two but no more than three members are physicians. It is clear that physicians are not to dominate the Board.

In addition, the governor would appoint an agency General Counsel who would supervise a cadre of staff attorneys whose primary responsibility would be to represent claimants — for free — before the Hearing Officers and the Board. In all likelihood the attorneys hired to represent claimants will be pro-consumer, similar to those found in other state agencies now.

The triers of fact, called Hearing Officers, would be empowered to take evidence and seek independent consultation from a medical or legal advisor, if they deem necessary. The Hearing Officer is not to

be a physician but rather someone who, over time, will acquire all the expertise required. Two faults: Hearing Officers are to be appointed as career bureaucrats with jobs, tenure, salaries, etc. protected by the state civil service commission. Second, there is no professional background or education required in order to be appointed by the civil service commission.

#### B. The Adjudicative Procedure

In lieu of current court procedures, the claimant merely files a simple one-page charge against the physician. Complaint forms are to be readily available at all state-wide government offices. Clearly this simple step will encourage claimants to seek compensation and will likely greatly increase the frequency of claims filed.

Once a charge is filed, it goes to an agency staff Claims Reviewer who is empowered to obtain all relevant records, interview the patient and the physician and then evaluate the charge. The Reviewer may add to the persons charged any other health care provider he thinks is involved in the injury.

The standard for finding fault is much lower under the AMA proposal than under the court system. Rather than determining whether the physician negligently "caused" the injury (i.e. the substantial factor or "but for" test to ensure that there is a valid casual link between negligent medical treatment and the injury) the standard is lowered to whether the physician's negligence "was a contributing factor" in causing the patient's injury.

On the positive side of this proposed change is the fact that the physician's liability would be limited to his/her degree of contribution. Each physician would not be liable for the contribution of any other individual, including the patient's own contributing negligence.

The Claims Reviewer may dismiss any charge he finds utterly



"without merit" or may dismiss the charge against anyone who he finds has made no contribution to the injury. The claimant may obtain review of the dismissal by a member of the agency Board simply by filing a form. The review is "de novo"; that is, a new independent evaluation. In the event of a second dismissal by the Board member, the claimant may, within 120 days, hire his own lawyer, get a physician expert to say that the claimant has suffered an injury which was "contributed to" by the health care provider, and then pursue his claim before the full Board.

If the Claims Reviewer believes that the physician's action or inaction may have contributed in some way to the injury, then the file is reviewed by a medical doctor in the physician's medical specialty. If the reviewing physician decides that the defendant did not contribute to the injury, then the Claims Reviewer seeks a second opinion. Nice, huh? If both experts agree that there is no reasonable basis to believe that the physician did anything which contributed to the injury, then the charge is dismissed.

If either reviewing physician concludes that there is a reasonable basis to believe that negligence did contribute to the injury, then the case is assigned to an attorney in the agency's General Counsel office who will offer to litigate the case on behalf of the claimant — free of charge. Currently, a claimant must pay his lawyer's out-of-pocket expenses (several thousand dollars, at least) even if the attorney takes the case on a contingency fee basis. Under the AMA proposal all financial disincentive to pursue the matter against the physician has been removed. Obviously, patients will have a "nothing to lose" attitude and most will elect to pursue their claim. The claimant retains the right to hire his own lawyer (even on a contingency fee basis) to assist or even replace the agency attorney.

At this point the agency proce-

dures are designed to force a settlement by the physician's insurer. In order to properly protect the physician and meet the AMA requirements, MAG Mutual will have to expand its claims staff. Among other things:

1. Insurer is given only 60 days within which to complete its investigation and obtain expert opinions in support of the physician. This is not nearly enough time to properly investigate the matter.

2. During the first 60 days both the claimant and the defendant MUST make a blind offer to settle the case to the Hearing Officer. If the offers overlap, the claimant will receive his offer plus 50% of the overlap.

3. After 60 days a settlement conference is held during which the Hearing Officer attempts to mediate a settlement. If the claimant chooses to be represented by an agency attorney, he is supposed to accept a settlement offer that is found by the General Counsel's office to be reasonable. If the patient refuses, he retains the right to get private counsel and proceed further.

4. If the claim is not settled at the conference, the parties are permitted discovery but it is limited to 30 interrogatories and no more than 3 depositions. This will result in inadequate case preparation and physician defense.

5. After discovery is complete, the parties are again required to submit blind settlement offers which must involve some amount of money. If the claimant does not ultimately recover more than the defendant offered, then the agency (or claimant if he uses a private attorney) will have to reimburse the defendant's attorney's fees and costs. And vice versa. This the AMA believes will encourage reasonable and realistic settlement offers.

6. The Hearing Officer is not required to listen to any oral testimony. In fact, he is encouraged to decide the case solely on the basis

of documents, depositions, etc. In reality, then, the very common problem of incomplete or inaccurate medical records, charts, shorthand notations, nurses notes, etc. will hurt the defendant who may not be allowed to testify as to what really happened.

7. After the Hearing Officer's decision, either party may appeal to the full Board within 30 days. Appealable issues are to be legal, not medical or factual issues, and, if the Hearing Officer's findings are supported by the evidence, then his decision will be affirmed by the Board.

8. Decisions of the Board are binding precedent on future cases.

9. Appeals from Board decisions are to be very limited. Its findings on fact and law are "conclusive" unless the Board acted arbitrarily or abused its authority. Appeal is to the state Appellate Court whose power is limited to affirm the Board's decision or remand the matter to the Board for reconsideration. The court has no authority to decide liability or damages issues.

### MAG Mutual Closed Claim Study

How would Georgia physicians fare under the AMA state agency arbitration system? MAG Mutual conducted a study of 1,565 claims closed between June 1, 1982 and April 1, 1988. We found:

- A) Of 1,565 claims closed:
  - 206 claims, or 13%, closed with indemnity payments to a claimant as well as defense costs.
  - 772 claims, or 49%, closed with defense costs, but no payment to a claimant.
  - 587 claims, or 38%, closed with no payment of any kind.
- B) 58 trials completed:
  - Won 48, or 83%, with a jury verdict for physician.
  - Lost 10, or 17%, with a jury verdict for claimant.
- C) Of the 70 claims closed with an



indemnity payment to a claimant of \$100,000 or more:

- Average indemnity of claims of \$100,000 or more was \$355,704.
- An average of 20% of award/settlement, or \$71,141, attributable to pain and suffering.

## D) Loss Adjustment Expenses (LAE):

- Total LAE paid on all 978 closed claims with LAE was \$4,841,000.
- Average LAE paid was \$4,950.
- LAE payments are 18% of total payments (claims and LAE paid).
- 62% of LAE spent on claims closed without payment to claimant.

## E) Insurance Company General and Administrative expenses:

- 6.9% Expense Ratio for 1987 at MAG Mutual.
- 20.1% Expense Ratio for 1987 at St. Paul.

I need to explain how the closed claim study of MAG Mutual allows us to state so categorically that the pain and suffering and no merit assumptions underlying the AMA's proposal do not reflect our loss experience here in Georgia.

## AMA: 80% of Large Losses are for Pain and Suffering

The vast majority of the 206 claims closed with settlements or jury awards consist of compensation to the claimant for his/her past and future out-of-pocket expenses (surgery, hospitalization, medicine, medical equipment, nursing care, etc.) and lost past and future wages. Of the 70 claims closed at \$100,000 or more, an estimated average of only 20%, or \$71,141 of such payments were for pain and suffering. This is true even in the catastrophic losses evoking a lot of sympathy for the injured. Only 2 of 1,565 closed claims have resulted in payments where the majority of the amount is classified as "pain and suffering" compensation.

## AMA: 57% of All Claims Have No Merit

While 587, or 38%, of the claims were closed without payment of any kind, it would be erroneous to jump to the conclusion that the claim was "without merit" or frivolous. These began as precautionary notices reported by physicians who had a patient who experienced an unexpected, adverse medical outcome to a treatment or procedure. A preliminary investigation by a Claims Representative at MAG Mutual revealed an unexpected patient injury and some reasonable argument that the insured physician did something or failed to do something which caused the injury. So a claim file was set up. It was subsequently closed when no demand for compensation materialized. *The claim is not without merit, merely not pursued!*

Under the AMA agency proposal which makes filing a complaint simple and easy at no cost to the injured patient, we believe that many, perhaps most, of those 587 or so claims closed without any payment at all would have been filed and would have been paid under the administrative agency concept the AMA proposes.

In addition, another 772, or 49%, of the closed claims involve payment of loss adjustment expenses (LAE), but no indemnity payment to a claimant. Many cases involved only a modest amount spent for obtaining medical records, physician review, etc. and some cases involved upwards of \$75,000 to even \$100,000 for a trial in which we won a defendant's verdict. The average LAE on these cases was only \$3,890. Likewise, we believe many of these 772 claims would result in compensation being paid under the AMA proposal.

Our loss reserves on this 87% of all claims, the 1,359 claims closed without indemnity payment in these two categories averaged only \$24,283 per claim, but in sum totaled \$33,000,000. If these were

paid, it would cause the Georgia physicians' premiums to double. By comparison, the total amount of indemnity MAG Mutual paid on all 1,565 closed claims was \$22,379,000. Adding additional payments of \$33,000,000 would increase the total losses paid to over \$55,000,000; more than double the amount actually paid. If physicians' premiums are at current levels when only 13% of *reported* injuries get paid, how high would premiums be if most injured patients received compensation?

Actually the proposal is probably much worse than our statistics show. We believe that currently only a small percentage of medical negligence injuries get reported and become a claim. The AMA proposal may well open the floodgate for claims. Patricia M. Danzon in her book *Medical Malpractice, Theory, Evidence and Public Policy*, Harvard University Press (1985), analyzed independent studies on the frequency of compensable injuries. She estimates that at most 1 in 10 patients injured in a hospital filed a claim and that less than half of those who filed a claim received any compensation. Thus, she concluded, that "the incidence of malpractice is much higher than the frequency of malpractice claims" (p. 4).

Without debating the degree of accuracy in the various studies on patient injuries resulting from medical negligence, there is much evidence that there are many times the frequency of patient injuries than there are medical liability claims. It is our contention that a simple, free administrative agency adjudication process would result in a very large increase in the number of claims being filed against physicians, and many more than 13% of them would get paid.

Let's assume that the number is not 1 in 10 injuries that ever become a claim; let's use 1 in 5. That means that there may be 4 more potential claims out there for every



1 currently being reported. Under the AMA proposal if even half of the 4 unreported compensable incidents become claims, then frequency will triple. The AMA will achieve its objective; its proposal will correct the fact that the current judicial system does not compensate a significant number of patients who have been injured by medical accidents. And the physicians will pay for the correction.

## AMA: Judicial System is Expensive and Juries are Inconsistent

The AMA's third assumption for its proposal may be summarized as the current judicial system is time-consuming and expensive with currently less than half of total premiums ever reaching the injured claimant. In addition, jury awards are increasing and are often inconsistent. These points are true. However, the fact that the system is time-consuming and expensive are among the reasons why many more claims are not filed. These things have, in fact, moderated the premium increases we have witnessed over the last few years.

The point which the AMA makes that 57% of physicians' premiums are eaten by claims "process" costs is true. MAG Mutual rates are set such that 100% of physicians' premiums go to defend and to pay claims. The company operates on investment income. An aggregate allocation of distribution of physicians' premiums is:

	Premiums
Plaintiff's attorney and expenses	40%
Defense attorney and expenses	18%
Plaintiff	42%
	100%

However, the distribution needs to be analyzed to see whether there can be expense saving which might benefit physicians. On the 206 claims closed with indemnity, we

spent \$1,838,000 on defense costs; only 7.6% of the indemnity paid to the claimants. However, we spent an additional \$3,003,000 investigating and defending 772 cases which we ultimately closed without any indemnity payment to the claimant. Of the total amount paid by MAG Mutual, 18% was for defense attorneys and other claim related expenses.

Under the AMA proposal loss adjustment expenses would, in fact, jump sharply because the vast majority of the 1,359 claims closed either with no payment at all or only a small LAE payment would end up being pursued by the injured patient and arbitrated before the Board. In addition, if half the current injuries which are not reported become complaints and frequency triples, then that will drive LAE skyward.

One significant improvement in the AMA proposal is the elimination of the 40% of the indemnity payment which goes to the plaintiff's lawyer since the agency itself would represent injured patients. For our 206 claims closed with indemnity, this would represent a savings of nearly \$9,000,000. But a savings to whom? To the plaintiff, not the physician.

Plaintiff's cannot now add their attorney's fees to their list of damages when proving their case in court. Juries do not normally add to the verdict an additional amount to pay the plaintiff's lawyer. We acknowledge, however, that some verdicts are inflated by juries because they know that the plaintiff's lawyer is going to take a portion of the award and they want to make certain that the amount "will take care of" the plaintiff.

We believe that eliminating the plaintiff's lawyer from the process will increase the percentage of the award going to the injured patient; this is meritorious. However, the savings will not benefit the physician or reduce his/her premiums.

Finally, the AMA asserts that the

current tort system which relies heavily upon juries is not optimally suited for resolving medical negligence. Jury awards are often inconsistent and are increasingly excessive.

MAG Mutual has tried 58 lawsuits and the juries returned a verdict in favor of the physician defendant in 48, or 83%, of the cases. Admittedly we try to settle claims which we are certain to lose in court and so these statistics are more favorable than if we tried more of the adverse cases. However, we willingly try cases if we believe that we have a reasonable chance of winning, or even if we know we are going to lose, but the plaintiff's settlement demand is unreasonable.

Statistically we ought to be losing nearly half of the cases we try, but we're not. We are losing only 17% of the trials. Why? Because juries in Georgia respect physicians and try to view the facts in the light most favorable to the physician. It is our belief, that, on the whole, juries in Georgia are very fair to Georgia physicians. They are pro-physician. It would be a mistake to give this up for the sake of preventing the rare outrageous jury award.

## Rulemaking and Discipline Functions Under AMA Proposal

The AMA proposal grants to the agency an extensive role in physician discipline and credentialing in addition to its medical negligence adjudication responsibilities. Although MAG Mutual is not an appropriate advisor on these issues, we will set forth some of the Board's duties in these areas so that physicians and medical organizations may be aware of and consider them.

### A. Rulemaking

Upon notice to medical and legal groups, the Board may promulgate rules which have the effect of law including issuing rules interpreting specific medical practice standards adopted by medical societies. Thus the Board could adopt certain "safe



harbor" rules that protect physicians who follow an approved course of treatment. Likewise, failure to follow the rules could be "negligence per se."

### B. Discipline

The Board is given overall responsibility to review and monitor every physician's performance for purposes of credentialing and discipline. Every adverse liability determination will trigger some level of review of the physician's practice. At a minimum the investigation will entail a review of the Board's central data bank on prior claims, discipline, and restrictions which will be part of every physician's file.

AMA proposes periodic review of every physician's performance by two entities — his/her medical liability insurer and a hospital. The reviewing entities would be required to report to the Board's central clearinghouse any adverse action taken. Every physician would be required to apply for medical liability insurance. If he/she cannot secure insurance, the Board would review whether that fact merits action to limit the scope of the physician's practice.

The hospital credentials committee will be required to review the records of all physicians applying for hospital privileges and to reexamine the credentials every two years, using JCAHO standards plus CME participation, audit of patient charts, and medical liability history. After notice to the physician and a hearing, recommendations concerning restrictions, suspension or termination of hospital privileges will be made to the Executive Committee of the hospital staff, which in turn, will make its recommendation to the hospital Board. This does not seem to be a dramatic departure from present practice — just more extensive. Physicians without hospital privileges must make special arrangements for periodic review as a condition of licensure.

Under the AMA proposal every physician will be *required* to report incompetence, mental or physical impairment or drug or alcohol dependence of a fellow physician to an impaired physician committee of the hospital or medical society. Confidentiality and immunity from liability will be granted to the reporting physician.

The AMA proposal makes CME mandatory and every physician will have to document his/her participation. Continued eligibility for liability insurance will require participation in the insurance company's mandatory loss prevention program. Likewise, hospitals will offer mandatory assurance/loss prevention programs to its medical staff.

Finally, as part of its quality monitoring activities, the agency Board would be authorized to conduct an on-site audit of the medical practices of any physician who has had a medical liability payment. The focus of the audit, the AMA proposes, is rehabilitation and education; discipline only as a last resort.

The agency Board will receive and investigate complaints from the public as well as hospitals and physicians and the Board itself. The non-physician Claims Reviewer will handle the investigation and recommend further action to the Board's General Counsel. If the Claims Reviewer concludes that there is reason to believe that a physician's skills are inadequate or that he may be impaired, then the physician's records will be ordered produced and an audit made on-site which will be reviewed by physician peers. Again confidentiality and immunity are provided to everyone involved in the review.

Once the matter is investigated, the Board's General Counsel will decide whether to initiate a disciplinary charge against the physician. If such a charge is filed, then the matter is heard by a Hearing Officer and a determination made of:

- a) no action.
- b) referral to impaired physician program.
- c) other sanctions; e.g. performance monitored.
- d) license restriction or revocation.
- e) summary disciplinary action; e.g. immediate suspension.

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## COMPUTERS IN MEDICINE

William C. Pfister, M.D.

**W**e continue to perform our function of helping to inform Georgia physicians of the variety of ways in which computers can assist them in their practices.

Because so many MAG members have asked us for recommendations of computer hardware or software the Committee has carefully considered several courses of action. Even though at least one metropolitan medical society in our State has endorsed an individual computer system, we continue to believe that MAG recommendations of particular products or vendors are inappropriate, and that selection of the right product or service depends on the physician's individual practice and needs.

As an aid to our members, we have commissioned an article on selecting a medical computer system for publication in the *Journal of the Medical Association of Georgia*. Written by Robert R. Moore, Jr., Atlanta medical practice management consultant, the article, "Doctor, Before You Buy that Computer . . .," should be of considerable help to our membership. We hope to continue to provide this kind of information in the future (see the Recommendation appended to our report).

In their reading, our Committee members from time to time come upon a particularly worthwhile ar-



ticle on medical computing. Such a one is "Advanced Computing for Medicine," by Glenn D. Rennels and Edward H. Shortliffe, published in *Scientific American* last October. To call it to the attention of MAG members, we have provided a brief summary of the article for the MAG *Newsletter*.

"ELECTRONIC MAIL": Last year the MAG House resolved that the Association should "investigate the feasibility of developing for its officers, key members and local societies and any member who desires to participate, an appropriate on-line computer system for transmitting information."

The Committee has discussed this possibility, particularly in reference to the Georgia Interactive Network for Medical Information (GalN). GalN, in fact, submitted a proposal to provide such an electronic mail system for MAG members. We discussed GalN, its price (\$300-\$450 per user, annually) as well as its alternatives or competitors. We then voted to recommend, given the existence of more economical means of non-computerized communication (e.g., organized telephone calling by staff to key county society headquarters), that MAG not enter a contract with GalN at the present. The MAG Executive Committee endorsed our recommendation last December.

I should add that the efficacy of mass telephone communication was demonstrated in the last week of the recent General Assembly, when MAG officers, staff and Auxiliaries mobilized an impressive telephone campaign which resulted in hundreds of calls to State Senators in less than 12 hours. This experience suggests the wisdom of MAG continuing to pursue alternatives to computerized "electronic mail" as a means of quick communication.

As Chairman, I would like to commend the members of our Committee for their help and enthusiasm in our project. They are:

Abdulla M. Abdulla, M.D.  
James A. Brennon, M.D.  
Leonard Brubaker, M.D.  
Thomas W. Carswell, M.D.  
Robert R. Collins, M.D.  
David Harvey, M.D.  
William M. Headley, M.D.  
Charles Ingram, M.D.  
Ken Lindyberg, M.D.  
Sam Mendel, M.D.  
William Rawlings, Jr., M.D.  
George W. Shannon, M.D.  
Tyson D. Smith, M.D.  
Norman Worsley, M.D.  
John Zimmer, M.D.

## Recommendations

That the MAG, through its *Journal* and *Newsletter*, continue to help disseminate timely information on the various applications of computers in medical practices.

## House Action

Adopted.

## MAG MEMBERSHIP COMMITTEE

Ralph Tillman, M.D.

The MAG Membership Committee met twice during 1987. The Committee's members expressed interest in a new membership recruitment brochure; expansion of the MAG MIS (Membership Information System); and a solution to the ongoing concern for component societies which cannot maintain enough members to remain chartered.

## Recruitment

The Membership Committee has collected recruitment brochures from each state Association and is in the process of studying these brochures to determine new, effective approaches to our ongoing recruitment pursuits. An updated, concise brochure briefly detailing the many benefits of MAG partici-

pation is planned, with recruitment mailings to begin following this Session of the House of Delegates.

## Young Physicians Section

An organizational meeting of the proposed MAG Young Physicians Section was held during the January, 1988, Leadership Conference. Much energetic enthusiasm was expressed by the young physicians in participating in the many facets of organized medicine.

As mentioned at the AMA Regional Membership Meeting attended by staff in August, 1987, 52.6% of the physician population are young physicians, with 18.3% of the young physicians being female.

The Committee is especially interested in attracting this sector of the physician population to MAG membership, as the young physicians not only represent a large group, but a viable voice concerned with leadership in medicine.

## Membership Increase

Progress is being made on the Committee's continuing effort of identifying types of nonmembers currently listed on the MAG masterfile, with 3,498 nonmembers classified, as follows:

Residents	1043
Students	728
Osteopaths*	4
Past members	
(not in practice)	9
Past members (out of state)	172
Past members (didn't renew)	1451
Past members	
(license suspended)	3
Retired	17
Military	6
Other prospective members	
(not previous members, in Georgia)	65

\* The only Osteopaths whose records are now maintained on MAG's system are those who are members of a MAG-staffed specialty society.



Currently, 3853 nonmembers' practice types have not been defined, and further information is being collected, via component societies and the American Medical Association's "Physician Movement Reports." When nonmember classifications have been completed, the Committee plans to target specific groups in special membership recruitment mailings.

### Masterfile Expansion

Further expansion of the MAG database during 1987 included recording members' telephone numbers, and, to date, 70% have been input. This information proved particularly beneficial to those participating in the extensive telephoning from the MAG headquarters office, appraising members of 1988 state legislation.

Also now being recorded are members' types of practice, i.e., solo, group, hospital-based, etc.

The Committee's projected goal is to have complete biographical information on the MAG masterfile on all physicians in Georgia, both members and nonmembers.

### Tort Reform Assessment

There are only 71 members who did not pay the 1986 mandatory tort reform assessment, representing collections from 98.5% of those assessed. Delinquent members' special requests were referred to the MAG Judicial Council, and each physician has been contacted to determine why they did not contribute. Reinstatement or other action was taken on an individual basis.

### County Medical Society Update

Although there are two remaining societies which have not elected officers, the Committee would like to commend the Bartow County Medical Society, which underwent a major reorganization during 1987. Bartow has elected new officers, again become more an active society, and has increased its mem-

bership from six to fifteen active members during the past calendar year.

Currently, seven local societies are not maintaining the required five active members necessary, in accordance with MAG Bylaws, to retain their charters. These societies have been "borderline" on and off for at least ten years, attracting enough members for short periods of time, then again falling below the required membership. The members of these societies have been requested to assist MAG in attracting new members in their areas; however, there are no new physicians establishing practice in these counties. As a second option, members of these societies with continually insufficient members have been requested to affiliate with adjacent societies. The general consensus of these members in rural areas is that they do not wish to transfer their membership to neighboring societies of larger, metropolitan areas.

### Recommendation

That the MAG establish an "at-large" membership category to accommodate those members who practice in areas of the state which are unable to maintain five active members, and that the MAG Bylaws be amended appropriately to include this "at-large" status of membership. "At-large" membership would be limited only to physicians in those areas which do not have sufficient physicians to maintain a component society.

### House Action

Adopted *as amended* to read: "That the MAG *consider establishing* an 'at-large' membership category to accommodate those members who practice in areas of the state which are unable to maintain five active members, and that the MAG Bylaws be amended appropriately to include this 'at-large' status of membership. 'At-large' membership would be limited only to

physicians in those areas which do not have sufficient physicians to maintain a component society."

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## NON-PHYSICIAN HEALTH CARE PROVIDERS COMMITTEE

**Richard W. Cohen, M.D.,  
Chairman**

**T**he Non-Physician Health Care Providers Committee met twice during the year, largely discussing legislative issues regarding non-physician providers and how the Committee could be of assistance.

### Occupational Regulation Review Council Meets First Test: X-Ray Technologists Licensure, HB 143

The legislation passed in 1986 which called for review of any proposed licensure or certification legislation by the Occupational Regulation Review Council passed its first test. The Council, headed by the Director of the Governor's Management Review Division, met five times during the summer and fall on HB 143, providing for the certification of X-ray technologists. After much study, the Council unanimously recommended not to certify X-ray technologists, stating that such governmental regulation would not lead to the increased safety and well-being of the citizens of Georgia. As a result, the author of the bill asked that HB 143 not be considered during the 1988 session of the General Assembly. MAG had presented extensive written and oral testimony opposing this bill.

### Physical Therapists, SB 292

The Physical Therapy Association had written a new and broader definition of physical therapy and



hoped to have it incorporated in legislation that had passed the Senate in 1987 (SB 292). They had even met with some physicians (independent of this Committee) who had accepted their new definition.

The Non-physician Health Care Providers Committee then met with several members of the Physical Therapy Association to discuss the proposed definition change and other concerns of mutual interest. The Committee was not satisfied with the new definition because it too was overly broad. A major medical concern for the safety and well being of patients was that there was not enough understanding of the role of diagnosis in physical therapy. The representatives of the Physical Therapy Association could not explain how one can successfully treat a patient without first making the correct diagnosis, or how you can make a correct diagnosis without having extensive training. Not having reached an agreement, the Committee instructed the legislative team to continue to oppose SB 292, which was successfully accomplished.

The House of Representatives held public hearings on the bill, at which time two MAG physicians presented expert testimony. The House Health and Ecology Committee decided to hold the bill, and therefore it did not pass.

It is expected that the Non-physician Health Care Providers Committee will continue its efforts to see if there is common ground that can be obtained with the physical therapists.

### **Senate Health Professionals Study Committee Established**

The Senate passed a resolution establishing the Health Professions Study Committee to be composed of five senators. The stated purposes of this committee is to determine if "it would be more practical and economical to provide for the licensing and regulation of a member of health-related profes-

sions by a single examining board." The committee will be following the Senate committees and provide input into its study. The report is due to the Senate by December 1, 1988. The Non-physician Health Care Providers Committee will be monitoring the Study Committee during 1988.

### **Audiologists and Speech Pathologists**

The Georgia Speech-Language-Hearing Association has hired a lobbyist. In 1987 they tried to pass legislation that would require physicians to hire only licensed audiologists to perform hearing tests in the physician's offices. It appears that they may try to do this again in 1989.

### **Recommendations**

1. That the Non-physician Health Care Providers Committee continue to monitor the various non-physician health care provider groups and their legislative goals.

2. That the Non-physician Health Care Providers Committee meet with the various non-physician provider groups to discuss issues of common concern.

3. That the Non-physician Health Care Providers Committee watch for any activity by any group that might have an adverse impact on the health and safety of the consuming public.

### **House Action**

Adopted all three Recommendations with commendation.

## **PUBLIC HEALTH COMMITTEE**

**Gray Rawls, M.D.,  
Chairman**

*Referred to: Rec. 1 — Reference Committee C; Rec. 2 — Reference Committee A.*

**D**uring 1987-88, the MAG Public Health Committee lent its support to the Association's vigorous strides in AIDS prevention and education — the continuing number one public health concern in Georgia and the nation. As chairman, I was pleased to participate on the specially-appointed MAG Ad Hoc Committee on AIDS which linked the Public Health Committee's previous efforts and spearheaded a vibrant new Association leadership to our physicians and community.

Following the publication of a major Association report on AIDS in July, 1987 by the Ad Hoc Committee on AIDS, the Public Health Committee continued its educational partnership with the Georgia Department of Human Resources to produce an AIDS Physician's Education Slide Module. The 52-set slide program for physicians synthesizes clinically-relevant information detailing basic clinical guidelines, AIDS case reporting, patient counseling, and AIDS education and information. The CME-approved presentation may be used by hospital medical staffs, county medical societies, and group practices for information and discussion or individual use with audiotape or printed text.

For 1988-89, the committee is studying the possibility of a physician's clinical protocol on AIDS which would very clearly and simply lay out in booklet form the latest information on test reporting, clinical manifestations of HIV infection, diagnostic evaluation, treat-



ment, and education and counseling. With the number of individuals with HIV infection increasing nationwide and within our state, now ranked eighth in prevalence rates, physicians and clinics will be seeing more people with symptoms of HIV infection or concern about AIDS. They will need to recognize and evaluate those patients who have increased risks or signs and symptoms suggesting infection. This clinical guide will be one among the ongoing efforts of the Association to provide current, useful information to both the medical community and the public on HIV and AIDS.

Secondly, during the last year, the committees gave both financial and ongoing staff support to health risk appraisal testing in Georgia high schools. In June, 1987 the committee promoted statewide programs of health risk testing at the Department of Education's Wellness I State Conference. The staff presented to health educators throughout the state a synopsis of the health risk testing program, and the Association's view on healthy lifestyles and implications for health educational curriculum. An updated version of the risk profile has been prepared with accompanying computer discs which may be made available to local school systems and educational training centers in Georgia.

In a separate but related activity to health risk testing, the committee also carried through with the actions of the 1987 MAG House supporting the Drug Free Schools and Communities Act of 1986 and the Cobb County Medical Society's Adolescent Urine Drug Screening Program. The Committee offered its endorsement of the teenage drug testing program and supported increased media exposure by the Association. This was done in the form of an Association news release on February 5, 1988 — "Drug Screen Program Keeps Kids off Drugs"; publication of a MAG *Journal* arti-

cle in December, 1987, "Adolescent Urine Drug Screening: A Cobb County Medical Society Program"; and endorsement letters to the Georgia Department of Education. The Cobb UDS is now operating in five county medical societies — Cobb, Clayton, DeKalb, Fulton, and Muscogee, and has been endorsed by a long list of distinguished groups and individuals including the Georgia Legislature, the State Superintendent of Schools, the Metro Atlanta Council on Alcohol and Drugs, the Georgia Psychiatric Association, and the Georgia Society for Adolescent Psychiatry.

MAG's Public Health Committee met three times this past year. As chairman, I wish to express appreciation to the following members of the Public Health Committee who willingly gave of their time and expertise to these projects during the year:

Benjamin S. Anderson, Jr., M.D.  
William R. Elsea, M.D.  
A. A. McNeill, Jr., M.D.  
S. Charlotte Neuberg, M.D.  
Elton S. Osborne, Jr., M.D.  
Betty B. Wray, M.D.  
Gunar N. Bohan, M.D.  
Harold P. Katner, M.D.  
Walter Murray, Jr., M.D.  
Benjamin B. Okel, M.D.  
Wells Riley, M.D.  
Mrs. Thomas W. Marks

### Recommendations

1. The Public Health Committee recommends that the MAG support the development of a physician's clinical protocol for AIDS and HIV infection which emphasizes clinically-relevant information, appropriate assessment, and patient counseling. The purpose being to enhance the success of public health efforts to prevent AIDS by the integration of HIV assessment and counseling in the clinician's daily practice of medicine.

2. We request MAG's support for promotion of the high school health risk appraisal program in local

school systems throughout Georgia.

### House Action

Adopted Recommendation 2.

See Report of Reference Committee C for House Action on Recommendation 1.

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## PUBLIC RELATIONS COMMITTEE

**Jeffrey T. Nugent, M.D.,  
Chairman**

*Referred to: Rec. 1 — Reference Committee A; Rec. 2 — Reference Committee F.*

**A**t the 1987 meeting of the Medical Association of Georgia House of Delegates, the Public Relations Committee recommended the development of a public awareness effort aimed at improving healthy lifestyle habits among Georgians. The House of Delegates, in its final action, approved that recommendation, which included continuation of MAG's teenage pregnancy prevention campaign, "You Can Say No"; creation of AIDS education materials; and development of an overall healthy lifestyle program.

What follows is a breakdown of each public education effort — what was done, and what remains to be done to carry out the House directive.

### "You Can Say No" Teenage Pregnancy Prevention Campaign

This campaign, a joint MAG/Auxiliary effort, was launched on January 21, 1987 at a press conference in Atlanta, and has been one of our most successful efforts, to date. It has received national attention and has gained the respect of such notables as the Governor of Georgia and the United States Secretary of Education, Dr. William Bennett. The program was featured at the recent



AMA Leadership Conference in Chicago, and our classroom component entitled "Postponing Sexual Involvement," developed by Grady Teen Services in Atlanta, was a curriculum model for the Sex Education bill considered by this year's Georgia General Assembly.

In measuring the impact our program has had on Georgia, we need only look at the increased awareness and numerous responses we have had since the January 1987 kickoff.

We have received almost 500 requests for information or materials. We have disseminated over 40,000 "You Can Say No" buttons, 25,000 bumper stickers, 20,000 brochures and 3,000 information packets. Our two television public service announcements have been aired between 50 and 100 times per month throughout the state, and one of the spots just received a Telly award for local and regional television commercials. And we have had numerous requests for speakers on this subject for media interviews, schools, and civic groups. In addition, a recent study by the Ford Foundation showed that 8th grade girls who had not had the "Postponing Sexual Involvement" program were three times more likely to begin having sex in 8th grade than those who had had the program.

At the start of the 1987-88 school year in August, there was a resurgence of interest in our campaign. Due to this unanticipated but pleasant surprise, the Public Relations Committee spent almost \$8,500.00 on reprints of materials and training sessions for auxiliary members participating in our school component. We felt this to be a very worthwhile expenditure for both MAG and the Georgia public who benefited from our program. The program has been a big boost to the public image of MAG and physicians, and was a 100% production of MAG and the Auxiliary.

### **AIDS Education Program — "Fighting Fear With Facts"**

As AIDS became more and more prevalent throughout Georgia and the nation, public fear grew and the need for proper AIDS education increased. It therefore became apparent that MAG needed to take a leadership role in Georgia in AIDS education efforts. Therefore, the MAG Executive Committee created the Ad Hoc Committee on AIDS, comprised of the following experts: Jack F. Menendez, Macon, Chairman; O. Grey Rawls, Albany (Chairman, Public Health); Beverly B. Sanders, Jr., Macon, (Public Relations Committee Representative); O. Wytch Stubbs, Tucker (Chairman, Medical Practice); W. Douglas Skelton, Macon (Chairman, Georgia Task Force on AIDS); Hans J. Peters, Columbus (Pathologist); Rudolph Jackson, Atlanta (CDC Representative); Joseph Wilbur, Atlanta (DHR Representative); John F. Fisher, Augusta (MCG Representative); Walter J. Hill, Atlanta (Psychiatrist); W. Daniel Barker, Atlanta (Georgia Hospital Association Representative); Mrs. Roy W. Vandiver, President, A-MAG. The role of the Public Relations Committee, as delegated by the Ad Hoc Committee on AIDS, was to develop an AIDS brochure and other AIDS education materials.

The Public Relations Committee, with assistance from the auxiliary to the MAG, created the theme, "Fighting Fear With Facts," and developed various materials for statewide distribution.

We, in conjunction with Richard E. DuBois, M.D., Atlanta, developed a brochure entitled, "AIDS: Fighting Fear With Facts"; several fact sheets; backgrounders; a resource list; a speaker's bureau; sample speeches; and sample news releases and editorials. With assistance from the Public Relations firm of Lewis, Clark and Graham, we also developed a poster entitled, "This is a Mandatory AIDS Test."

As with our teen pregnancy prevention materials, these materials were very popular. They were first completed and distributed to MAG physicians in September of 1987, and since that time we have disseminated over 30,000 brochures, 10,000 posters, and 1000 information kits. The AIDS materials were also distributed to the entire Georgia General Assembly to help facilitate passage of the AIDS bill.

As another measure of this program's success, the Centers for Disease Control (CDC), who has spent over 14 million dollars to create their own AIDS education materials, which unfortunately were not mailed out nationwide amid promises they would be, has repeatedly ordered our materials. In addition, the "This is a Mandatory AIDS Test" poster recently won a gold Addy award in the public service category from the Atlanta Advertising Club. The Addy is the highest honor bestowed on advertising creations.

The success of these materials was costly, however, attributing to over \$22,000 (almost half) of the Public Relations budget. We feel, however, that this was and will continue to be a priority issue for MAG to address.

### **Healthy Lifestyle Campaign, "A Prescription for Life"**

This campaign has been slow to get off the ground due to our other expenditures and programs, but we have made a bold start and have laid out the entire program for the 1988-89 MAG year.

The overall objective of this campaign is to promote healthy lifestyle choices among Georgians in an effort to improve physical fitness and healthy eating habits, as well as decrease abuse of tobacco, alcohol and drugs, and lessen stress, etc. The longterm goal of the campaign is to position physicians as experts in helping Georgians make the right healthy lifestyle choices.

At present, we have produced a



30-second television public service announcement which is beginning to be aired across the state. MAG is also spearheading a wellness consortium created by WPBA Channel 30 in Atlanta. The station produces a show entitled "Healthstyle" every Wednesday from 6:00-6:30 p.m. and we provide a MAG member panelist for every show. Panelists we have provided, thus far, are:

Jack F. Menendez, M.D., MAG President, "Your Own Healthstyle"; Sanford Matthews, M.D., Pediatrician, "Your Happy, Healthy Child"; W. Douglas Skelton, M.D., Chairman, Georgia Task Force on AIDS, "The Reality of AIDS"; Joe B. Massey, M.D., Gynecologist, Infertility Specialist, "Overcoming Infertility"; Herbert R. Karp, M.D., Neurologist, Geriatrics, "The Elderly"; Charles P. Yarn, Jr., M.D., Plastic Surgery, "Cosmetic Surgery"; Frederic C. McDuffie, M.D., Internist, Rheumatology, "Chronic Illness"; William H. Whaley, M.D., Oncologist, Hematology, "Caring for Your Terminally Ill Loved One."

We have also prepared camera-ready copy for four patient brochures which we will print over the next few months. The brochure topics are fitness, addiction, stress and auto safety. The firm of Lewis, Clark and Graham designed our brochure artwork, and a sub-committee of experts assisted our staff in writing these brochures. John Cantwell, M.D. assisted in preparing the fitness brochure; Doug Talbott, M.D. helped to prepare the brochure on addiction; Sheldon Cohen, M.D. gave assistance in writing the stress brochure; and Boyd Eaton, M.D. assisted in preparing the brochure on auto safety. We are considering additional brochures on topics such as pediatrics, heart disease, cancer, arthritis, and elderly health.

A brief summary of further components of the Healthy Lifestyle program follows:

- Build Campaign around the theme, "Healthy Lifestyle, A

Prescription for Life."

- Produce an additional 30-second television Public Service Announcement (PSA) for state-wide distribution as followup to the first PSA.
- Produce two 30-second radio spots — one for adults, one for teenagers — that mesh with television PSAs for uniformity.
- Print and distribute up to six patient brochures and counter card for doctor's offices, hospitals, etc. on *fitness*, which includes exercise, weight control and nutrition; *addiction*, which includes smoking, alcohol and drugs; *auto safety*, which includes drinking and driving and seat belt use; and *stress*. Additional topics will be determined at a later date.
- Design a media kit which includes a series of articles written by MAG physicians (12, for once a month insertion) for distribution to local newspapers.
- Produce a video, using prominent sports and entertainment figures, aimed at teenagers, to be used in schools.

A unique feature of this Healthy Lifestyle campaign is that it utilizes cooperative efforts of county medical societies and county auxiliaries in localizing the program and making it more appealing to local media. With this in mind, we have developed several campaign components that call upon county medical societies to take action. These components include:

- Create a summer public event in as many areas of the state as possible, to gain exposure for the program such as a Fun-Run, Health Fair, etc. using key radio or TV stations around the state. Local auxiliaries may be used to help organize the event.
- "Medical Minute" — pre-written, 60-second TV and radio PSAs from MAG sent to county medical societies for local production, using local physicians.

These taped spots are then distributed to local media by the county medical society.

- Pre-designed public service ads sent to county medical societies for insertion in high school newspapers stressing healthy lifestyle choices for teens.
- Local speaker's bureaus to be organized or re-organized to provide healthy lifestyle speakers to schools, businesses, etc.
- County medical society media kits with sample, fill-in-the-blank health articles, provided by MAG, and utilized locally.

## Other Activities MAG's PR Committee Has Been Involved In This Year

1. Following the House of Delegates in April, we distributed some of the key House actions, in the form of news releases, throughout the state.

2. Our PR staff responded to several county medical society requests by drafting letters to the editor or editorials for publication in local papers.

3. We obtained publicity via a news release and media interviews, for the MAG-endorsed Adolescent Urine Drug Screen Program, started in Cobb County.

4. Our PR staff fielded calls from the public and the media on such topics as AIDS, indigent care, ritalin, tort reform, and regulation of physicians.

Finally, MAG's Public Relations Committee met three times in 1987-88. At the last meeting, in March of 1988, the committee members established a new policy whereby any printed campaign materials — e.g. brochures, fact sheets, etc. — printed by MAG will include adequate blank space for county medical societies and county auxiliaries to add in their own logos or message.

The Chairman wishes to thank the members of the P.R. committee who gave a great deal of their time and energy to our projects during the



past year, and particularly Mrs. Sherry Marsh, our staff representative, who has handled our in-house work.

Sheldon Cohen, M.D., Kathy Easterling, M.D., James G. Killebrew, Jr., M.D., Thomas A. Lyons, M.D., Charles W. McDowell, Jr., M.D., Christian R. Moorhead, M.D., Toby S. Morgan, M.D., Alan Pomerance, M.D., Beverly B. Sanders, Jr., M.D., Gerald Stapleton, M.D., Joseph W. Stubbs, M.D., Mrs. Roy W. Vandiver, William Weston, M.D., and Edgar Woody, M.D.

The Chairman also wishes to thank Jack F. Menendez, M.D., MAG's President, for his tremendous leadership this year, and Joe P. Bailey, M.D., MAG's President-elect for his incoming leadership.

## Recommendations

1. That the major public relations project for 1988-89 will be Healthy Lifestyles — a comprehensive program of public education with grass roots involvement of the county medical societies.

2. The Public Relations Committee requests \$60,000 to carry out its programs for FY1988. (See attached itemized budget.)

## House Action

Adopted Recommendation 1.

See Report of Reference Committee F for House Action on Recommendation 2.

## ATTACHMENT

### Public Relations Expenditures

June 1987-January 1988

<b>AIDS Materials:</b>	
Design of AIDS logo, layout, typesetting, printing (folders, brochures), reorders	\$ 8,320.00
Typesetting, printing of AIDS teenage brochure	1,401.81
Design, typesetting, printing AIDS posters	5,066.80
Duplicating, dubbing, adding logo, mixing of AMA AIDS spot and Red Cross Video	2,657.60
Purchase of Red Cross Video	237.71
Purchase of AMA AIDS spots	225.00
Reprints of AMA AIDS monographs	180.60
Duplicating Red Cross slide show	835.66
TV news clip of AIDS coverage	71.00
Purchase of AIDS teen materials	17.19
Postage for all-member mailing of AIDS materials	3,500.00
Postage for full AIDS Information Kits to CMS and Auxiliary officers and staff	250.00
<b>Total</b>	<b>\$22,763.37</b>
<b>Healthy Lifestyles Materials:</b>	
Complete development, casting, production, editing of 30-second TV spot	\$11,000.00
Design of counter Card, brochures, print ad	3,134.37
<b>Total</b>	<b>\$14,134.37</b>
<b>Teen Pregnancy Materials:</b>	
Grady Teen Services Training Kits and Seminars	\$ 822.00
Reprint of brochures	3,190.58
Reprints of buttons and bumper stickers	4,695.21
Reprints of Videotapes	84.95
<b>Total</b>	<b>\$ 8,792.74</b>
<b>Travel, clipping service, administrative:</b>	<b>\$ 2,805.44</b>
TOTAL EXPENDITURES	48,529.66
LESS REVENUE	4,160.50
<b>Net Expenditures</b>	<b>\$44,396.16</b>

## Public Relations Expenditures

February 1988-March 1988

Based on additional \$25,000.00 allotted to Public Relations Committee from MAG Board of Directors Contingency Fund:

Produce 15 each of 2 brochures (i.e. — 30 brochures per physician)	\$ 9,000.00
Produce 1 counter card per physician	6,000.00
Label, insert, seal, bundle	1,000.00
Postage (3rd Class Bulk)	9,000.00
<b>Total</b>	<b>\$25,000.00</b>

## Proposed Public Relations Expenditures

June 1988-May 1989

Follow-up television public service announcement	\$ 10,000
Remaining public awareness brochures (healthy lifestyles)	30,000
Adolescent video, featuring celebrities, for school use (co-sponsored by outside funding)	10,000
Media materials	3,000
Teenage pregnancy, AIDS education materials	4,000
Travel, clipping service, administrative:	3,000
<b>Total</b>	<b>\$ 60,000</b>

## AD HOC COMMITTEE ON AIDS

Jack F. Menendez, M.D.,  
Chairman

## Introduction

The Ad Hoc Committee on AIDS was established to develop and recommend AIDS policy guidelines, disseminate educational materials and programs for physicians and the public, and coordinate other MAG committee activities concerning AIDS.

In recognition of this significant health care problem, MAG established a committee of experts to study and make recommendations concerning what Georgia's physi-



cians consider to be the most important communicable disease hazard in our State. The committee consists of representatives in the specialties of surgery, family medicine, pediatrics, pathology, psychiatry, internal medicine, dermatology, as well as representatives from the Centers for Disease Control, the Georgia Hospital Association, The Department of Human Resources, The Auxiliary to the Medical Association of Georgia, the Mercer University School of Medicine, the Medical College of Georgia School of Medicine, the Morehouse College School of Medicine, and the Georgia Task Force on AIDS.

We met four times during 1987 with our first meeting in July to begin developing an official MAG set of recommendations for our member physicians. We studied all materials that the American Medical Association had published and numerous articles and publications from other organizations. We began to outline recommendations that the Task Force felt would benefit not only the medical community but the general public as well.

## Statement on AIDS

Our efforts began to take form as a report to the MAG Board of Directors. The purpose of the report is to provide relevant guidance and suggestions to physicians, health care providers, state government, the General Assembly and the public as each attempts to comprehend and effectively respond to this growing health crisis. Twenty recommendations with informational background were submitted. The following are the Medical Association of Georgia's recommendations to the groups named above:

1. Fight Fear With Facts. Only through education can accurate information to both health care professionals and the public be provided.

2. Education and counseling are significant tools in preventing the

spread of HIV.

3. Physicians should consider incorporating into their practice standard procedures for taking complete sexual and drug use histories of their patients and should have candid communication with, and participate in the education of persons known to be at risk of HIV.

4. Physicians, nurses, and other health care providers are urged to provide competent and humane care to all patients, including patients infected with HIV, or who have developed ARC or AIDS.

5. Counseling and testing for the AIDS virus should be readily available to all who wish to be tested.

6. Mandatory testing of the general population or even all hospital or emergency room admissions is not necessary at this time, however there is an appropriate role of some limited mandatory testing. (Discussed in detail in other recommendations).

7. Testing for the AIDS virus should be mandatory for donors of blood and blood fractions, organs and other tissues intended for transplantation in the U.S. or abroad, for donors of semen or ova collected for artificial insemination or in-vitro fertilization, for immigrants to the United States and for military personnel.

8. Testing for the AIDS virus of local, county and state prison inmates should be mandatory if the sexual and drug use history of the inmate indicates any high risk behavior; likewise, the test should be available for any inmate requesting the tests. Additionally, jails and prison systems should meet their obligation to protect the general (unexposed) prison population by segregating HIV seropositive patients.

9. Counseling and testing should be strongly encouraged and offered for the following individuals in the following settings:

a. Patients at sexually transmitted disease clinics

b. Patients at drug abuse clinics

c. Pregnant women at high risk

d. Individuals seeking family planning services who are at high risk or who engage in high-risk practices

e. Patients requiring surgical or other invasive procedures who are at high risk or who engage in high-risk practices. If the voluntary policy is not sufficiently accepted or if a treatment facility is located in an area with a high incidence of AIDS, the treatment facility and medical staff should consider a mandatory program for the facility. This should be on a case-by-case basis and should not apply to all treatment facilities.

10. Absent a specific patient directive, a physician should exercise medical judgement when ordering an HIV test.

11. Physicians should assist patients with AIDS in coping with the reality of the generally fatal nature of the disease.

12. HIV test results, ARC, and AIDS information should be treated as confidential medical information the same as any other medical information.

13. Physicians and certain other health care providers should be given the statutory authority to notify third parties who may be at risk of infection from a patient of the physician.

14. Individuals who are found to be HIV seropositive should be reported to appropriate public health officials on a confidential basis with enough information to be epidemiologically significant.

15. Civil and criminal sanctions should be imposed against those who are HIV seropositive and who fail to act responsibly to prevent the spread of the virus.

16. Physicians should enter HIV test results into the patient's medical record.

17. The General Assembly should revise the present O.C.G.A.



31-14, "Hospitalization for Tuberculosis" and O.C.G.A. 31-12, "Control of Hazardous Condition, *Preventable Diseases* and Metabolic Disorders" to comply with current due process procedural requirements.

18. The Department of Human Resources is encouraged to increase its program of contact tracing. The Georgia Assembly is urged to provide adequate funding.

19. The Department of Human Resources should develop a comprehensive plan to deal with the long-term health care needs and related costs of AIDS and ARC patients.

20. Children who are HIV seropositive or have ARC or AIDS should be allowed to attend school. Additionally, sex education including AIDS information should be included in the school's curricula.

These recommendations were approved by the MAG Executive Committee at its November meeting in hopes to aid the Georgia General Assembly in considering the many AIDS-related bills that were introduced at the 1988 Legislature.

### Legislation

Over ten AIDS-related bills were introduced by various legislators; however only HB 1281 was passed. This comprehensive bill combined numerous AIDS-related issues such as the confidentiality of medical records, counseling, AIDS-related crimes, etc. The MAG played a major role in ensuring that the legislation remained focused on the medical issues and did not become a punitive measure nor a new social doctrine.

### Publications

Through the efforts of the MAG Public Relations Committee a campaign on the prevention of AIDS was initiated. MAG's Communications Department began to accumulate data in hopes of educating the general public on the issue of AIDS.

Considerable effort and expense was applied to the issue of education. Posters, pamphlets, videos, speakers, and slide shows were made available on a statewide basis. A poster titled "This Is A Mandatory AIDS Test" won an Addy Award for its effectiveness.

### Recommendations

1. That the MAG Task Force on AIDS continue its mission of constantly monitoring the medical and social aspects of AIDS and provide additional recommendations as needed to assist Georgia physicians in treating and preventing this dreaded disease.

2. That the MAG Task Force on AIDS, in conjunction with the MAG Legislative Council, compare the recently passed Georgia AIDS law in relation to MAG's statement of recommendations, and present any needed statutory changes to the 1989 General Assembly.

### House Action

Adopted both Recommendations.

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## AD HOC COMMITTEE ON MEDICAL CARE FOR THE DISADVANTAGED

**John Rhodes Haverty,  
M.D., Chairman**

*Referred to: Rec. 1, 3 — Reference Committee A; Rec. 2 — Reference Committee C.*

**"A**ppoint a Gubernatorial Study Committee, expand Medicaid to cover additional groups, encourage employer health coverage and don't deny medical care because of a patient's lack of funds." These top the seven recommendations made by the Ad Hoc

Committee on Medical Care for the Disadvantaged and adopted at the 1987 MAG House of Delegates meeting. The report was the culmination of a special project initiated in 1986 by MAG President, John D. Watson, Jr., M.D., to study ways that "medicine might address the important issue of medical indigency."

Following the year long probe, the committee presented a three-pronged approach for dealing with the problem: Legislatively, Professional Association Initiatives, and Private Business Planning. This report reemphasizes the Association's call to action and describes some approaches currently underway.

### Legislative

Although the Governor chose not to appoint a special study committee in 1987-88, state legislators are discussing the possibility of taking a hard look at the topic in 1988. One of the few measures which was passed by the Georgia Legislature was Senate Resolution 350 which allows for a constitutional amendment to be placed on the November ballot authorizing an Indigent Care Trust Fund. The fund would be used to broaden Medicaid coverage and expand health care funding in rural and primary health care areas.

The Georgia Medicaid Program also continued its growth pattern in 1988 by increasing indigent medical care funding, through a \$19 million enlargement in its FY 1989 budget — an amount intended to give medical care to additional numbers of pregnant women and children.

### Professional Association

How the profession itself has assisted the disadvantaged patient is hard to define in exact terms. Information from the American Medical Association survey data indicates that it is significant. The AMA's 1983 Socioeconomic Monitoring System survey showed, for exam-



ple, that some 76.8% of all physicians provided some free or reduced fee care and potential revenues were reduced 9.1% by providing care to patients who were unable to pay. Many Georgia physicians provide reduced fees through their participation in the Medicaid and Medicare Programs. Findings from the Georgia Physician Survey conducted in 1986 show, for example, that some 71.2% of physicians accepted Medicaid patients and 83.8% accepted Medicare. A number of local medical societies and physician groups continue to offer free medical care clinics in their own communities.

### Private Business

Private business has become more and more interested in issues of employee health care and insurance coverage as costs have spiraled. The Atlanta Healthcare Alliance, one of several business health coalitions organized in the state, initiated two projects toward alleviating Atlanta's problem with the uninsured — a small employer survey in the Atlanta area and a low-cost private sector plan to cover employees of small businesses. They plan to act as a catalyst for the private and public initiatives to address this enormous community problem. Georgia physicians will need to play an important role in these attempts to find low-cost premium plans.

Finding solutions to the problems of indigent care constitutes a formidable task. The committee's recommendations to expand health insurance to cover the uninsured, broaden Medicaid, and provide greater free care are general approaches only. Clearly, the development of an insurance program for the millions of uninsured would require careful planning. At this stage, it is essential that we acknowledge that the problem of health care for the poor has not been solved. Medicine has a big role to play in the consideration of this

problem by business groups, legislators, and the insurance industry. Consequently, I wish to recommend the following:

### Recommendations

1. That the Association reaffirm the actions of the 1987 House of Delegates relating to medical care for the disadvantaged, including the request that its members continue their personal commitment to caring for all patients regardless of their ability to pay.

2. That MAG continue to press for Georgia legislative and gubernatorial action concerning health care for the disadvantaged.

3. That MAG offer special impetus and support to the 1987 recommendations concerning the expansion of employee health insurance coverage to all employees.

### House Action

Adopted Recommendation 1.

Did not adopt Recommendation 3 but adopted in lieu thereof the following substitute recommendation, adopted by the 1987 MAG House of Delegates: "That the MAG encourage employers to provide health insurance coverage for all their employees and urge insurance companies to facilitate this outcome."

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## RESOLUTION 8

### Medical Association of Georgia's Involvement in the Adolescent Urine Drug Screening Program

#### Cobb County Medical Society

*Whereas*, the Adolescent Urine Drug Screen Program of the Cobb County Medical Society has now been in operation since June, 1985; and,

*Whereas*, the Program is now also active in DeKalb, Muscogee, Clayton, and Fulton Counties under the auspices of their respective medical societies, basically using the Cobb County Medical Society model; and,

*Whereas*, the Medical Association of Georgia's House of Delegates endorsed the Program in 1986; and,

*Whereas*, interest continues to grow in this Program state-wide, e.g., Georgia Senate Bill 641, as well as numerous endorsements by other organizations and prominent persons; now, therefore, be it

RESOLVED, that the Adolescent Urine Drug Screen Program became an official activity of the Medical Association of Georgia, under the auspices of the Medical Association of Georgia's Public Health Committee; and be it further

RESOLVED, that the Medical Association of Georgia continue to promote this Program to its component medical societies to encourage each county society to set up a similar Program.

### House Action

The first *Resolved* portion of this recommendation was adopted as amended to read: "Resolved, that the MAG Adolescent Urine Drug Screen Program be endorsed by the Medical Association of Georgia and be referred to the Public Health Committee."

Adopted the second *Resolved* portion.

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## RESOLUTION 15

### Alcohol Awareness Information

#### Ogeechee River Medical Society

*Whereas*, the alcoholic beverage industry advertises heavily over radio and television to increase sales



of alcohol products; and,

*Whereas*, increased consumption correlates directly with increased problems from alcoholism and alcohol misuse; and

*Whereas*, alcohol advertising is a major strategic method not only to shift the norm to increased drinking but to recruit new, young, and healthy consumers; and,

*Whereas*, many listeners and viewers, who cannot or should not use alcohol, may be subjected to this advertising; and,

*Whereas*, facts about the dangers of alcohol are not available to all the people influenced by such advertising; now, therefore, be it

RESOLVED, that the American Medical Association work stringently for legislation and regulations that would require radio and television stations to provide free equal time for the presentation of alcohol awareness information.

### House Action

Adopted as amended to read: "Resolved, that MAG recognize the seductive nature of television and radio alcohol advertising on the public, and specifically on young people, and that the appropriate MAG body be directed to evaluate the possibility of requiring warning labels and language on alcohol products and in advertising and that such activity be recommended to the AMA for further investigation, and possible application to national alcohol advertising."

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## RESOLUTION 31

### Treatment of AIDS Patients

#### Georgia Medical Society

*Whereas*, the number of Georgia physicians specializing in the treatment of infectious diseases and most prepared to care for AIDS pa-

tients is extremely small; and

*Whereas*, the number of AIDS victims in Georgia is expected to rise dramatically during the next decade, imposing increasing strains on medical manpower and facilities charged with treating those patients; and

*Whereas*, the AIDS patient faces long-term illness and massive medical costs frequently after having lost his or her health insurance benefits, forcing hospitals and physicians to deal with the prospect of unreimbursed care which further encourage referral to a small number of facilities and small number of specialists; and

*Whereas*, many physicians, either because of dread of AIDS, lack adequate clinical knowledge of AIDS or have abrogated their responsibilities, tend to refer *all* patients away from their care to the aforesaid facilities and to the small number of specialists; therefore, be it

RESOLVED, that the Medical Association of Georgia reaffirm the moral and ethical obligation of all physicians and facilities to care for patients presented to them including patients with AIDS, and communicate this obligation to its membership; and be it further

RESOLVED, that the Medical Association of Georgia begin to address the problem of a potential shortage of physicians and facilities specializing in the treatment of AIDS victims; that recommendations are made concerning funding (state, insurance, federal or other third party) to appropriate authorities, such as insurance companies, Georgia legislature, Georgia Department of Human Resources, and the Georgia Department of Medical Assistance. Medical schools and training programs should be encouraged to address the potential shortage of trained specialists such as infectious disease specialists and provide for increased training in care of AIDS patients by all primary care specialists.

### House Action

Did not adopt the first *Resolved* as stated, but adopted in lieu thereof the following substitute resolution which was adopted by the 1987 MAG House of Delegates: "Resolved, that the Medical Association of Georgia affirm its support for the dignity and self respect of all medical patients; and be it further

*Resolved*, that the MAG affirm that all medical patients should enjoy all the opportunities and privileges for work, education, and association consistent with the facts of their medical condition and the basic principles of public health, and be it further,

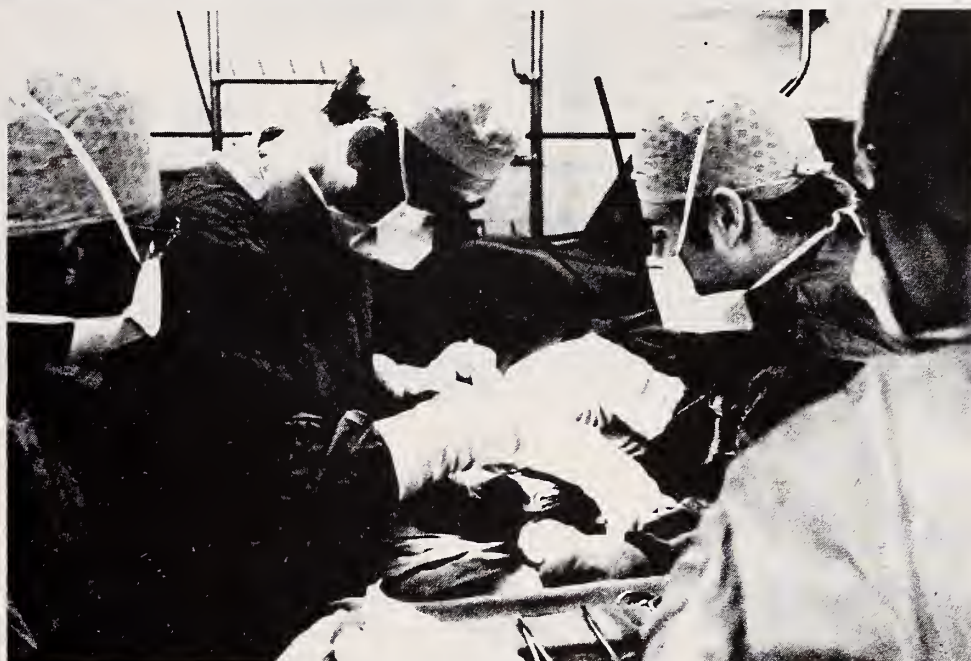
*Resolved*, that the MAG affirm its opposition to all forms of prejudice against any medical patient."

Adopted the second *Resolved* portion of the resolution *as amended* to read: "Resolved, that MAG, realizing that the growing problem of AIDS can result in a potential shortage of physicians and specialized care facilities for AIDS patients, strongly recommends that: medical schools and training programs be encouraged to address this potential shortage by providing for increased training in care of AIDS patients by all primary care specialists; and MAG develop recommendations concerning funding to appropriate authorities."

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# Report Reference Committee

# B



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## COST AWARENESS COMMITTEE

**W. John O'Shaughnessey,  
Jr., M.D., Chairman**

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**R**eference Committee B gave careful consideration to its referred reports and resolutions. The following physicians were members of that committee: A. H. S. Weaver, Chairman, Macon; Donald H. Campbell, Vice-Chairman, Marietta; Hugh S. Thompson, Jr., East Point; Patrick J. Evans, Savannah; Albert A. Carr, Augusta; Larry Brightwell, Columbus; Stefan H. Fromm, Dalton; Clinton E. Branch, Gainesville; Joseph V. Morrison, Savannah; and H. Gordon Davis, Jr., Sylvester.

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**T**he Cost Awareness Committee did not meet this year. It is my recommendation that this Committee be dissolved and that cost awareness activities continue under the auspices of the Georgia Health Network.

I would like to express my appreciation to the members of this Committee who have helped in developing effective programs for the membership.

### Recommendation

1. That this Committee be officially abolished.
2. That this Committee's functions continue under the auspices of the Georgia Health Network.

### House Action

Adopted Recommendation 1.  
Adopted Recommendation 2 as amended: "That this Committee's functions continue within an ap-

propriate committee appointed by the MAG President or Executive Committee."

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## MEDICAL PRACTICE COMMITTEE

**O. Wytch Stubbs, Jr.,  
M.D., Chairman**

**T**he Medical Practice Committee submits the following report to the MAG House of Delegates for its information and consideration. The following topics are addressed:

- Do Not Resuscitate Policies
- Home Health Services
- Physician Drug Testing
- *AMA Health Policy Agenda for the American People*

### DNR Policies

Reemphasizing a 1986 MAG House measure, the 1987 House again adopted a recommendation urging hospital medical staffs and administrators to adopt statements





*Members of the Reference Committee and guests listen to testimony from Dr. Ralph Tillman at the podium.*

of policy regarding Do Not Resuscitate (DNR) orders. A memorandum to this effect was sent to hospital medical staffs and administrators on September 28, 1987, as well as information referencing Georgia's Living Will Statute and a 1984 Georgia Court decision on termination of life support.

Similarly, at the 1987 AMA Interim Session, the Council on Ethical and Judicial Affairs recommended the adoption of DNR policies based on ethical, legal, and community standards consistent with any religious principles adhered to by the hospital (Report B, 187 of the Council on Ethical and Judicial Affairs). The report outlines seven suggested ethical and medical points which should be considered in drafting an appropriate statement of policy.

DNR policy development is particularly significant at this time due to the many variations of laws which exist among states and the recent court actions in Georgia and elsewhere. Also significant is the Joint Commission on Accreditation of Health Care Facilities' new standard, effective January 1988, which calls for development of a hospi-

talwide policy on the withholding of resuscitative services from patients.

In January, 1988, the Medical Practice Committee conducted a second follow-up survey on DNR policy development in Georgia hospitals. Findings showed that an additional 23 hospitals had reported having DNR policies in place with six more in the process of doing so, bringing to a total of 87 hospitals out of 148 reporting having DNR policies in place. An additional 11 hospitals reported having no policy, bringing to a total of 43 the number of hospitals in the state without policies on Do Not Resuscitate. A DNR resource packet has been prepared by the Association and is available to interested hospital medical staffs.

#### **Home Health Services**

Following the mandates of the 1988 MAG House of Delegates, the Georgia AMA Delegation introduced a Resolution at the AMA 1987 Annual Session which addressed topics on physician reimbursement in home health care (Res. 134) and quality assurance (Res. 135). Although Report EE of the AMA Board

of Trustees was adopted in lieu of the Resolutions, their intent was addressed in several actions: (1) through assembly of an AMA physician advisory group who would develop "a listing of services which might be appropriately reimbursable in the case management area"; and (2) through the AMA's participation on the Joint Commission on Accreditation of Hospitals' Home Health Advisory Committee. Many of the recommendations made in Report EE are supported by the Medical Practice Committee and are reiterated in the committee's recommendations.

The committee continues to remain concerned about the key issues mentioned above and, in general, of the limited role of physicians in the home health care system. During 1988-89, the committee will be reviewing the Georgia Medical Care Foundation's progress in conducting quality assurance reviews on home health agencies, a requirement of the sixth Omnibus Reconciliation Act of 1986, as well as other developments important to the practice of medicine.



### Physician Drug Testing

During 1987, the committee also prepared a statement on the topic of physician drug testing as requested by the MAG Board of Directors. The statement asked that "the Association reaffirm its admonition to Georgia physicians to a positive and chemical free life style." Further, they did not feel it would be appropriate to recommend any voluntary statewide physician drug testing program at this time due both to administrative constraints and to the questionable scientific and clinical bases for the valid use of these tests. This was received as information by the MAG Board of Directors.

### The AMA Health Policy Agenda for the American People

In 1987, Dr. E. C. Evans, Committee member, was appointed as the MAG's official representative to the AMA Health Policy Agenda. However, following the February, 1987 release of the HPA's final report, little AMA/State coordination has actually occurred. HPA staff have reported considerable progress in carrying out specific recommendations and indicate they will be involving state Associations much more closely in the months ahead. The HPA staff now identifies themselves exclusively as "AMA staff" and state they will be pursuing only those subjects peculiar to Association interests. Initiatives now encompass such areas as: Basic Benefits Package, Medicaid Reform, Compensation for Patient Injury, Certification in the Profession, Bio-medical Research, and Health Objectives for the Year 2000. The committee will continue to monitor these activities in 1988-89.

### Recommendations

1. That the MAG reaffirm its support of home health care as an alternative to hospital, nursing home or institutional care.

2. That MAG encourage physicians to take a more active role in

the provision of home health care.

3. That MAG continue to monitor the adequacy of the home health care system to meet the accessibility and quality of care needs of homebound patients, and develop additional recommendations as appropriate.

4. That MAG convey support to the Health Care Financing Administration of the results of the AMA's development of what constitutes extraordinary case management services, with an emphasis on those services specific to home health care.

### House Action

Adopted Recommendations 1 and 2.

Adopted Recommendation 3 as amended: "That MAG continue to monitor the adequacy of the home health care system to meet the accessibility and quality of care needs of home bound patients, and develop additional recommendations as appropriate."

Adopted Recommendation 4.

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## THIRD PARTY PAYORS COMMITTEE

**C. Peter Lampros, M.D.,  
Chairman**

*Referred to: Rec. 1, 2, 3 —  
Reference Committee B; Rec.  
4 — Reference Committee C*

**C**hanges in structure of the delivery of medical care over the past decade continue to adversely affect the professional independence of physicians, particularly in the reimbursement area. Third party payors, managed health care plans, large hospital chains, and governmental programs now exert considerable leverage on economic as well as clinical aspects of physicians' practices. The MAG Third Party Payors Committee considered many of

these pressing issues during 1987-88 and presents the following report to the MAG House of Delegates for their information and consideration:

### Physician Reimbursement Under Medicare

Tremendous physician concern remains over the continued barrage of reimbursement cuts and rule changes occurring in the Medicare reimbursement system. New reimbursement limits, fee freezes, inherent reasonableness rules, and threats for physician DRGs have presented yet another wave of aggravation and frustration for physicians. To address many of these concerns and in keeping with the MAG House mandate of 1987, the Third Party Payors Committee has taken steps to keep Georgia physicians better informed and assist them in their negotiations with fiscal intermediaries.

Medicare news updates have been provided throughout the year in a series of direct mailings to physicians, Association newsletter accounts, and more recently through physician seminars scheduled in locations throughout Georgia. Medicare Law Update Seminars held in February, 1987 were attended by over 900 physicians and their office staffs while anticipated participation for the March, 1988 MAG seminars will be well over 1400. Hundreds of Medicare-related inquiries are also handled on an almost daily basis by Association staff.

In consultation with the committee, the Association and the Georgia Health Network filed, in January, 1988, a Freedom of Information Act/Privacy Act demand with the Health Care Financing Administration (HCFA) on behalf of member physicians. The request was for release of those physicians' individual Maximum Allowable Actual Charge (MAAC) data which had still not been released and was necessary for deciding the physician's



participation status for this year. Over 1200 physician members authorized the demand to HCFA, who subsequently agreed to release the data. (See Report QQ of the AMA 1-87 meeting for an overview of physician payment under Medicare.)

### **PPO and Prepaid Health Plans**

At the 1987 House of Delegates meeting, the House Adopted Resolution 20 (Patient Rights and Health Insurance) which was referred to the Board of Directors and subsequently to the Third Party Payors Committee. In consultation with David Poythress and the Georgia Health Network, the committee agreed that some provisions in many HMO and PPO provider contracts had, in our opinion, a material adverse impact upon the quality of patient care in Georgia. Many of the standard contracts used by HMOs in Georgia to provide for the delivery of physicians' service allow the HMO to unilaterally change the terms of the agreement, subject to certain notice provisions of the participating physicians. These changes had, in some cases, affected continuity of patient care and placed the physician at a distinct disadvantage. The MAG Board agreed with these points and approved a four-point regulation proposal to the Georgia Insurance Commissioner which would address both PPO and prepaid health plan contracts. This was communicated to the Commissioner in February, 1987.

### **Physician Insurance Company Relations**

During 1987, it was brought to the committee's attention that third party payors and their representatives were requiring increasing amounts of physicians' time to obtain preadmission, presurgical and length of stay authorizations and to complete additional forms before payment is approved. In addition, many of the contacts brought into question the physician's medical

care decisions. The committee is concerned not only with the frequency and appropriateness of the contacts, but with the increased liability exposure of physicians whose patients are injured directly as a result of negative decisions of peer review organizations and third party payors. Many of these inquiries come from: (1) physicians or other company representatives they do not know; (2) organizations with which they are not familiar; and (3) under circumstances in which they do not have written authorization from their patients to discuss their cases over the telephone.

A committee survey conducted on the topic in February, 1988, showed the following: Of the 218 physicians who responded to the survey, roughly 80% felt that the third party payor inquiries were not conducted in a way to conserve the physician's time and energy. Over 77% of the physicians answering felt that the contacts were inappropriate or unnecessary to the utilization management process. In terms of time expended, at least half of the physician respondents indicated that they and their office personnel were spending from five to ten hours a week on the additional and unnecessary paperwork and contacts.

These issues are not new to the Association. In 1986, the MAG adopted a Resolution which supported payment for preadmission requests by third party payors. Also, during 1986, the AMA Council on Ethical and Judicial Affairs stated, "that physicians may properly seek to be compensated when third party payors request reports requiring extensive or complex services in their preparation."

In 1988, the committee will continue seeking strategies for solution of these problems. Specifically, we will: (1) be supportive to the AMA's work with the health insurance industry and other payors to increase the uniformity and streamline the programs; (2) seek to reaffirm basic

Association policy for proper payment of extraordinary time and effort; and (3) work with the Georgia Hospital Association's Utilization Quality Assurance Ad Hoc Committee to seek a unified approach to the problem.

### **Summary**

In addition to the above items, the Third Party Payors Committee also monitored the Blue Cross-Blue Shield's Diagnostic Testing Guidelines and Voluntary Incentive Program. The Guidelines continue to be promoted as an educational tool only, for physicians and hospitals and not for reimbursement purposes. In January, 1988, the committee also sponsored a special workshop on office-based ambulatory surgery held in conjunction with the MAG Leadership Conference.

### **Recommendations**

1. That the MAG call for real reforms in the Medicare Program including adequate funding of services, the elimination of unnecessary, bureaucratic red tape, and the maintenance of essential services for the high quality and accessibility of health care.

2. That the Association continue to keep physicians fully informed on Medicare law changes and other important insurance/reimbursement matters.

3. That the MAG work with the health insurance industry and other payors to increase the uniformity and streamline the administration of prior authorization and other utilization review programs.

### **House Action**

Adopted all three Recommendations.



### AD HOC COMMITTEE ON PRIMARY CARE

**James VanBuren, M.D.,  
Chairman**

**T**he Ad Hoc Committee on Primary Care was appointed to review and provide input on primary care participation within the Georgia Health Network (GHN). In this Committee's report to the 1987 House of Delegates, four recommendations were offered as a result of a survey of primary care physicians — Family Practice, General Practice, Internal Medicine and Pediatrics — in Macon and Warner Robins. In addition to the survey, the Committee requested input of appropriate specialty societies and other groups interested in primary care as it relates to alternative delivery systems.

As a result of actions taken at the 1987 House of Delegates, GHN did make an attempt to consider recommendations relating to primary care physicians. For example, GHN initiated a variable withhold percentage which to some extent recognized the increased risk and overhead costs inherent in the practice of primary care.

However, due to adverse financial results, many activities of GHN were curtailed before all of the Ad Hoc Committees' recommendations could be *fully* addressed. While it is not certain what role GHN will play in the future, we understand negotiations are continuing which could result in a statewide PPO or HMO joint-venture.

In any event, the Committee continues to feel that the primary care specialties are essential to provision of quality health care to Georgians. Alternative Delivery Systems, and in particular GHN, must have vigorous support by physicians in their specialties. No alternative system can survive and insure the de-

livery of quality care within competitive cost constraints without such support.

Accordingly, the Committee wishes to reaffirm the following recommendations:

#### Recommendations

1. That the specialty composition of GHN's Board and Committees should be proportionate to the membership of MAG;

2. That a variable withhold percentage should be developed to eliminate the disparity among specialties considering the risks and overhead costs inherent in practice of primary care;

3. That marketing information concerning any future activities of GHN should be carefully reviewed for accuracy; and

4. That MAG should monitor developments in corporate and contract medicine in the state and the results should be regularly disseminated to the membership.

As Chairman, I wish to thank the members of the Ad Hoc Committee on Primary Care for their efforts:

Rose Briglevich, Smyrna; D. Robert Howard, Macon; Eugene Jackson, Moultrie; David Morgan, Atlanta; Samuel Rauch, Gainesville; George W. Shannon, Columbus; Martin Smith, Gainesville; Oscar Spivey, Macon.

#### House Action

Adopted the first three Recommendations.

Adopted Recommendation 4 as amended: "That MAG should monitor developments in corporate and contract medicine in the state and the results should be regularly disseminated to the MAG membership."

### AD HOC COMMITTEE ON PRO REVIEW

**Sammie Dixon, M.D.,  
Chairman**

**D**uring the past year, this committee has met with representatives from the GMCF/PRO three times to discuss general concerns and review the following complaints:

1. By far, the largest volume of complaints have been related to inadequate documentation by physicians and inadequate review of documentation by GMCF.

2. Requests for information as a result of generic quality screening, in particular "abnormal results of diagnostic services which are not addressed and resolved, or where the record does not explain why they are unresolved."

3. Criteria "too strict."

4. Questions relating to the possibility of early discharge of patients (readmission within 14 days) — two complaints related to readmissions by different physicians.

5. DRG Attestation Certifications. Usually the attending physician felt that the information in the records justified the diagnosis assigned. In one instance, CVA vs Hemiplegia NOS, the DRG for Hemiplegia was assigned because a CT scan was normal. This case related to physician clinical judgment vs. definitions used in medical records, i.e., CVA — an acute, immediate event; Hemiplegia — long-term or chronic.

6. Differences of professional opinions relating to treatment.

7. Inappropriate level assignment by GMCF.

8. One physician received three different requests on the same patient at different intervals; quality assurance dated 6/2; DRG change dated 7/15; and questioning the medical necessity for admission dated 8/3.



9. Two complaints related to the fact that the notification(s) contain no signature so they don't know to whom the response should be directed.

10. Delayed responses from GMCF.

11. Limit of ten days for response from physician.

12. Lack of clarity in GMCF form letters.

13. One complaint related to a pattern of practice review by Prudential of one physician's charges for office visits during 1984-85. GMCF had reviewed his 1984 records but not those in 1985. Prudential takes the GMCF adjudication and its own in-house determination and extrapolates these over a longer period of time — in this case, two years. GMCF considers this type review as utilization review, which has been conducted since the inception of the Medicare Program.

Nearly all the cases involved in the above complaints were resolved in favor of the attending physician.

During this past year, the GMCF form letters have been slightly modified and are currently being revised again. Ralph Murphy, MD, was hired as Medical Director in July, 1987. He has greatly improved communication with physicians and the GMCF internal review process, i.e., training of physician advisors and assisting with problems at the initial screening review level. Complaints we have received have been greatly reduced, e.g., from May-September, we received 25; from September-March, we have received only four.

The GMCF reports that there were 77,733 cases reviewed from August '86 through December '87. Of this number, 1,640 were cases with an admission denial (utilization, prohibited action); 28,078 were cases which the review coordinators (RC-Nurse) identified as a failure of the generic quality screens (established by HCFA); 8,016 of these were confirmed as generic quality screen

failures by physician advisors (PA) at the first PA review; 1,544 were confirmed quality problems by a medical review committee which includes representatives in the physician's same specialty.

These 1,544 cases were assigned to one of the five severity levels: (1) quality of care not supported by medical records; (2) medical problem and/or management resulting in the potential for an adverse outcome although the patient was medically stable upon discharge or transfer; (3) same as #2, but patient was medically unstable; (4) medical problem/management resulting in an adverse outcome requiring additional medical or surgical treatment (excluding gross and flagrant violation); and (5) medical problem/management resulting in disabling/dismembering injury or death which otherwise might not have been expected to happen (includes gross and flagrant violation).

Of the 1,544 final determinations, (727) 47% were assigned to level 1; (554) 36% to level 2; (212) 14% to level 3; (35) 2% to level 4; and (16) 1% to level 5. With the exception of level 5, each level has three classes of intervention/thresholds before the sanction process begins, e.g., level 1 would require up to 12 confirmed quality problems before sanctions would be recommended; level 2 up to 10; level 3, three cases; level 4, three cases; level 5, only one. Any adverse determination triggers profiling, usually 100% review of all cases.

If you would like copies of the Quality Review Flow Chart and the Quality Intervention Plan, please contact Mrs. Butler, MAG Headquarters.

In addition to the above review, the MAG, GHA and GMCF conducted a Peer Review Organization Workshop: "PRO: A Medical Staff Overview," at Callaway Gardens, November 13-14, 1987. Invitees included MAG Board of Directors, Georgia medical societies, and Chiefs of Hospital Medical Staffs.

Around 100 physicians attended.

There is no doubt that the PRO scope of work will continue to expand. It is in the process of initiating review of patient care in Health Maintenance Organizations, Home Health Agencies, Hospital Outpatient Departments, and Skilled Nursing Facilities. Physicians' offices are not included at this time, but studies are underway to determine the feasibility and how to include them.

The Omnibus Reconciliation Act of December, 1987 mandates a number of changes — most of which appear to be beneficial to the physician. No implementation regulations have been developed at the time of this report.

We feel sure the PRO scope of work will be expanded as Quality Assurance efforts are expanded within the Medicare and Medicaid Programs. There are a number of Quality Assurance Guidelines already developed.

### Recommendations

That the MAG and GMCF/PRO use available resources to:

1. Educate physicians regarding the need to document actions taken or reasons for not taking actions relating to abnormal diagnostic tests and/or nontreatment of symptomatic secondary diagnoses;

2. Educate physicians regarding the need for a quick, complete response to the first "quality" notification. Currently, this is a form letter entitled, "Preliminary Quality Review Notification"; and

3. Urge actively practicing physicians to serve as physician advisors and on specialty review committees as needed by the GMCF.

### House Action

Adopted all three Recommendations.

Fourth recommendation added and adopted: "Insure that physician case data files be purged after two years if the threshold has not been exceeded."



### RESOLUTION 6

#### Regulation of Managed Care Agencies

##### Cobb County Medical Society

*Whereas*, "Managed Care" agencies are now overseeing and authorizing treatment plans for a large number of patients; and,

*Whereas*, these agencies require physician cooperation by way of "case management," "utilization review," "second opinions," etc. for certification of treatment plans; and,

*Whereas*, physicians must cooperate with these agencies or their patients will risk the loss of their insurance benefits; and,

*Whereas*, physicians, by cooperating with these agencies, are looked upon by patients as representatives of the insurance company; now, therefore, be it

RESOLVED, that MAG seek, through legislation or otherwise, the regulation of managed care agencies in the same way that insurance companies are regulated; and be it further

RESOLVED, that MAG seek, through legislation or otherwise, regulations to insure that, once a treatment plan is certified, the insurance carrier cannot deny payment for other reasons.

##### House Action

Adopted.

### RESOLUTION 7

#### Guide to Contracting

##### Cobb County Medical Society

*Whereas*, physicians are called upon to review and judge the merit of contracts relating to alternative

delivery systems prior to their signing those contracts;

*Whereas*, these contracts are most often written by the agency establishing the alternative delivery system; and,

*Whereas*, these contracts often contain provisions that can limit the delivery of care as well as provisions that can dangerously increase the physician's liability; now, therefore, be it

RESOLVED, that MAG reaffirm the importance to all physicians of reading, understanding, and, if necessary, seeking independent legal counsel prior to signing any contract that may affect the delivery of medical care; and be it further

RESOLVED, that MAG publish for its membership a guide to contracting including general contracting guidelines as well as specific recommendations regarding such elements as indemnifications and utilization reviews that may seriously limit the physician's ability to deliver quality care and increase the physician's liability.

##### House Action

Adopted the first RESOLVED as amended: "Resolved, that MAG reaffirm the importance to all physicians of reading, understanding, and seeking independent legal counsel prior to signing any contract that may affect the delivery of medical care; and be it further."

Adopted the second RESOLVED portion as amended: "Resolved, that the MAG Board of Directors consider publishing for MAG members a basic and simple guide to contracting, including general contracting guidelines as well as specific recommendations regarding such elements as indemnification and utilization reviews that may seriously limit the physician's ability to deliver quality care and increase the physician's liability."

### RESOLUTION 9

#### Georgia Health Network Assessment

##### James Q. Whitaker, M.D.

*Whereas*, at least one reason for the less than successful endeavor of the Georgia Health Network HMO has been identified as inadequate capitalization; now, therefore, be it

RESOLVED, that the House of Delegates of the Medical Association of Georgia vote a mandatory assessment of \$1,000.00 per member per year for a term of three (3) years commencing with dues payable 1989, said funds to be used for the further capitalization of the Georgia Health Network HMO.

##### House Action

Did not adopt.

### RESOLUTION 10

#### GHN Stock

##### James Q. Whitaker, M.D.

*Whereas*, the Georgia Health Network holds a State of Georgia license to operate an HMO; and,

*Whereas*, individuals have invested in a preferred stock in the Georgia Health Network; now, therefore, be it

RESOLVED, that the Medical Association of Georgia reassign the HMO license to the preferred stock holders.

##### House Action

Did not adopt.



### RESOLUTION 11

#### Georgia IPA

**James Q. Whitaker, M.D.**

*Whereas*, some physicians have joined an IPA and have contributed funds to capitalize this IPA; now, therefore, be it

RESOLVED, that the IPA elect a new independent Board of Directors to assume responsibility for the function of the IPA; and be it further

RESOLVED, that the remainder of the funds collected from IPA members and held in trust by the Medical Association of Georgia be refunded to the new Board of Directors of the IPA.

#### House Action

Did not adopt.

### RESOLUTION 13

#### Georgia Health Network (GHN)

**Muscogee County Medical Society**

*Whereas*, GHN started under the leadership and guidance of MAG with funding; and,

*Whereas*, GHN is now holding closed meetings in cities to start PPO's, and not inviting all members of GHN in that city; and,

*Whereas*, GHN is using money sent by uninvited GHN members to foster competing health care systems; now, therefore, be it

RESOLVED, that the Medical Association of Georgia (MAG) disassociate itself from GHN completely; and be it further

RESOLVED, that MAG collect immediately any money owed MAG by GHN; and be it further

RESOLVED, that MAG terminate assistance to GHN, either legally, administratively, or by personnel of

MAG; and be it further

RESOLVED, that MAG work to disband GHN and any assets left in GHN be refunded to its members on a pro-rata basis.

#### House Action

Did not adopt.

### RESOLUTION 19

#### Onerous Policies of Procedures from Third Party Payors

**William R. Hardcastle, M.D., Delegate, DeKalb Medical Society**

*Whereas*, third party payors and others are increasingly entering the practice of medicine by various means which interfere with the doctor-patient relationship; and,

*Whereas*, this intrusion into the practice of medicine (such as pre-admission certification by non-M.D. personnel, usually located hundreds of miles away from the doctor and patient, mandatory second opinions, etc.) is taking untold hours away from the private M.D. and his staff in order to comply with these payors' "guidelines"; and,

*Whereas*, no person is able to advise a patient better than that patient's hand-picked physician who is totally aware of that patient's total health history; and,

*Whereas*, physicians and their staff are wasting time away from what they do best, the care of the sick, in complying with these worthless and onerous "guidelines"; and,

*Whereas*, the only way in which these idiotic guidelines are going to be changed or deleted is by complaints and resistance from the insured patient, that is the person or employer who pays the insurance premium; now, therefore, be it

RESOLVED, that the physicians

of Georgia require the individual patient or employer to waste their time in complying with these idiotic and onerous procedures (such as pre-admission certification mandatory second opinion, concurrent hospital stay certification, etc.).

#### House Action

Adopted as amended to read: "Resolved, that MAG reaffirm that the ultimate responsibility of a medical bill is with the patient; and therefore, the responsibility of complying with third party payors guidelines requiring pre-admission certification and mandatory second opinions should rest with the patient in the absence of other contractual arrangements."

### RESOLUTION 21

#### Encroachment of Third Party Payor Inquiries on Physician Control of Patient Care

**South Georgia Medical Society**

*Whereas*, physicians suffer from an excessive number of time-consuming inquiries from third-party payors regarding the physicians' medical treatment decisions; and,

*Whereas*, many of these inquiries imply that the payor organization, without the benefit of medical training, is questioning the physicians' judgement relating to the particular patients' care; and

*Whereas*, these inquiries implicitly ask physicians to betray their confidential clinical relationships with their patients; now, therefore, be it

RESOLVED, that MAG conduct a cooperative study with third party payors and utilization reviewers to assess the possible detriment to patient care of excessive UR inquiries, and to arrive at an agreed upon pro-



tocol of inquiries, acceptable to both physicians and payors; and be it further

RESOLVED, that MAG urge Georgia physicians to release to payors the above important information only after securing formal permission from the respective patients; and be it further

RESOLVED, that MAG further encourage physicians to levy appropriate charges, in keeping with AMA Judicial Council decisions, against third-party payors in compensation for responding to inquiries.

### House Action

Adopted the first RESOLVED as amended: "Resolved, that MAG conduct a cooperative study with third party payors and utilization reviewers to develop a uniform and streamlined utilization review system. Such a system should avoid having as its main priority the detriment to patient care."

Adopted the second RESOLVED as amended: "Resolved, that physicians should be reminded to release physician-patient confidential information to third party payors only after securing a proper medical release from the respective patient."

Adopted the third RESOLVED as amended: "Resolved, that physicians may charge appropriate sums, in keeping with AMA Judicial Council decisions and various laws, to third-party payors in compensation for responding to certain inquiries."

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## RESOLUTION 24

### Treatment Guidelines for Terminal Patients

#### Dougherty County Medical Society

*Whereas*, the absence of universally accepted guidelines on medical care for terminally ill patients

creates a wide range of appropriate treatment modalities for physicians treating terminal patients; and,

*Whereas*, reviewers for the Georgia Medical Care Foundation, without the benefit of accepted guidelines for terminal patient care, have wrongly interpreted various physicians' treatment modalities as deficient, and have therefore generated letters citing the alleged deficiency, when there has actually been none; now, therefore, be it

RESOLVED, that the Medical Association of Georgia work with the Georgia Medical Care Foundation to consider appropriate modalities of treatment for terminally ill patients as well as for other patient groups for whom medical care guidelines may be inadequate or unclear, and to draft such guidelines as may be needed for the purpose of physician review by the GMCF.

### House Action

Referred to MAG Board for further study.

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## RESOLUTION 26

### Medicare

#### Ralph A. Tillman, M.D.

*Whereas*, Medicare requires annual consideration by the United States Congress in an attempt to maintain some degree of solvency; and,

*Whereas*, some of the more recent changes in Medicare laws and subsequent rules and regulations from the Health Care Finance Administration have imposed unbearable economic problems for some Medicare beneficiaries; and,

*Whereas*, these same rules and regulations have imposed ridiculous, onerous and ambiguous restrictions and possible sanctions on health care providers; now, therefore, be it

RESOLVED, that the Medical Association of Georgia strongly urge that the President of the United States appoint a bipartisan broad-based Task Force with the charge for expeditiously developing immediate and long range plans toward reforming the current Medicare system to one that is *properly financed*, provides health care *only* for those with *well-qualified economic needs*, establishes *reasonable deductibles* and *co-payments* for beneficiaries; reduces the conflict and erosion of the traditional doctor-patient relationship, and places quality of care as a top priority; and be it further

RESOLVED, that this effort be properly communicated to the MAG AMA delegates for promotion at the June AMA House of Delegates meetings and to all Georgia Senators and Congressmen, and be it further

RESOLVED, that the MAG is unalterably opposed to further nationalization of our health care delivery systems.

### House Action

Adopted the first RESOLVED as amended: "Resolved, that the Medical Association of Georgia go on record as supporting a Medicare system that is properly financed, provides health care only for those with well-established economic needs, creates reasonable deductibles and co-payments for beneficiaries; reduces the conflict and erosion of the traditional doctor-patient relationship, and places quality of care as a top priority";

Adopted the second Resolve.

Adopted the third RESOLVED as amended: "Resolved, that the MAG reaffirm that it is unalterably opposed to further nationalization of our health care delivery system."



## RESOLUTION 27

### Fiscal Impact of Third Party Payors' Administrative Regulations

**Harrison L. Rogers, Jr.,  
M.D.**

*Whereas*, the complexity of Medicare Rules and Regulations continue to grow inexorably with regard to what care can be given, in what setting and of what duration (preadmission certification, second opinion, concurrent review); and,

*Whereas*, the administrative complexities of all managed care systems including PPOs, IPAs and HMOs, likewise continue to grow; and

*Whereas*, these requirements, themselves, have an impact on the care patients receive as well as on the cost of providing that care; and,

*Whereas*, the cost of health care in the U.S. is of major concern to government, industry and the public; and our elected leaders are frequently asked for the causes of the increase in health care costs; now, therefore, be it

RESOLVED, that the MAG introduce a resolution to the American Medical Association House of Delegates calling on the AMA to institute a study of the fiscal impact of these multiple administrative requirements by all purchasers of care; and be it further

RESOLVED, that the MAG further call on the AMA to seek the assistance of the American Hospital Association to provide the same sort of data relating to the direct and indirect fiscal impact of these regulations on our hospitalized patients, and that this information be shared with the federation of medical societies and the public.

## House Action

Adopted.

## RESOLUTION 35

### Public Information Re: Medicare

**William C. Waters, III,  
M.D.**

*Whereas*, one of the duties of the physician, and hence of organized medicine, is to serve as patient advocate; and,

*Whereas*, recent Medicare statutes prohibit the physician from charging standard rates to patients on Medicare roles; and,

*Whereas*, newer guidelines, such as those requiring retroactive refund of physician fees, impose still further prohibitive penalties for treating Medicare patients; and,

*Whereas*, most over-65 patients are fiscally self-dependent and have private health insurance; and,

*Whereas*, these regulations therefore deprive the over-65 patient, even if affluent, of his economic viability and hence deny him a fair competitive position in the medical marketplace, particularly in the all-important arena of primary care; and,

*Whereas*, many primary care physicians are anticipating a 100 per cent overhead for Medicare patients by 1990; and,

*Whereas*, some primary-care physicians are reporting expectations of leaving practice because of this problem, and a striking decline in applicants to internal medicine training programs has been seen in the last two years, presenting further threats of unavailability of care; and,

*Whereas*, many physicians are declining to accept new Medicare patients, and certain such patients who are changing location or whose

physicians have retired are even now finding it difficult, at least in urban areas, to obtain a new primary doctor; and,

*Whereas*, it is predicted that the quality and quantity of care for this age group can only deteriorate further under such conditions of economic deprivation; and,

*Whereas*, a Presidential Commission consisting of seven economists has recently reported findings supporting this position, stating that Medicare legislation will have an adverse effect on the older population and is as practical as "solving the cancer problem by declaring it illegal"; and,

*Whereas*, the 65-and-older group is well known to require several times the medical care of younger groups, rather than less; and,

*Whereas*, these legislative restrictions have been enacted not only without the consent but in general without the knowledge of those affected; and,

*Whereas*, it appears that the powerful advocacy groups of the elder population (such as AARP) continue to support, rather than oppose, governmental action in these areas, apparently unaware of the inevitable consequences; and,

*Whereas*, the over-65 group has potent influence in the political arena (constituting 20% of population now, estimated 30% in 2010, with the highest voting record — 85% of any age group); now, therefore, be it

RESOLVED, that the MAG Executive Committee establish and appoint a Task Force to utilize any and all access routes to the press and other public information agencies in an effort to inform the older public in Georgia of the present state and consequences of existing Medicare regulations; and be it further

RESOLVED, that the AMA delegation be instructed by the House of Delegates to insist that the AMA dedicate an appreciable fraction of its resources to this public information effort; and be it further



RESOLVED, that the President and Executive Director urge other medical organizations in the state — including component county medical societies but also particularly such groups as the Georgia Academy of Family Physicians, the Georgia Society of Internal Medicine and the Georgia Chapter of the American College of Physicians — to set about informing their patients of the discriminatory processes operating against them; and be it further

RESOLVED, that although legal action initiated by physicians in this area is notoriously unlikely to meet with success, the MAG should nonetheless support and encourage any appropriate class-action suit which may originate with the Medicare population in their effort to claim equal economic rights and hence equal access to medical care.

#### **House Action**

Resolve 1 was referred to the MAG Board of Directors for funding and implementation.

Adopted Resolves 2 and 3.

Adopted Resolve 4 as amended, "that although legal action initiated by physicians in this area is unlikely to meet with success, the MAG should consider supporting, with the approval of the MAG Board of Directors, any appropriate class-action suit which may originate with the Medicare population in their effort to claim equal economic rights and hence equal access to medical care."

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## **RESOLUTION 38**

### **Medicaid Reimbursement to Children's Hospitals and Related Institutions**

**DeKalb Medical Society,  
Inc.**

*Whereas, every child deserves*

access to health care no matter the parents' ability to pay; and,

*Whereas, children's hospitals and related institutions have the medical expertise and technology to care for the sickest of children; and,*

*Whereas, Family Physicians, Pediatricians and Pediatric Specialists refer, admit and/or care for the sickest children in children's hospitals and related institutions, and presently these institutions take care of a disproportionate number of children whose health care is completely dependent on Medicaid; and,*

*Whereas, the difference between cost of care and reimbursement has become increasingly disparate, with the financial burden on institutions caring for such children becoming greater each year, resulting in a Medicaid compensation crisis; now, therefore, be it*

RESOLVED, that for the well being of children and to assure appropriate facilities are available in the future to meet their health care needs, Medicaid reimbursement to children's hospitals and related institutions must be revised with the specific intent of improving such reimbursement; and be it further

RESOLVED, that the Medical Association of Georgia urge the American Medical Association to assist in solving this persistent, and deteriorating problem of Medicaid compensation to children's hospitals and related institutions by transmitting this resolution to the A.M.A. for consideration at its House of Delegates meeting in June 1988.

#### **House Action**

Adopted first RESOLVED as amended: "Resolved, that for the well being of children and to assure appropriate facilities are available in the future to meet their health care needs, Medicaid reimbursement to children's hospitals and related institutions and physicians must be revised with the specific intent of improving such reimbursement."

Adopted second RESOLVE.

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## **RESOLUTION 39**

### **Medicare**

**Ralph A. Tillman, M.D.,  
Secretary**

*Whereas, Medicare requires annual consideration by the United States Congress in an attempt to maintain some degree of solvency; and,*

*Whereas, some of the more recent changes in Medicare laws and subsequent rules and regulations from the Health Care Finance Administration have imposed unbearable economic problems for some Medicare beneficiaries; and,*

*Whereas, these same rules and regulations have imposed ridiculous, onerous and ambiguous restrictions and possible sanctions on health care providers; now, therefore, be it*

RESOLVED, that the Medical Association of Georgia strongly urge the President of the United States to appoint a non-partisan, broad-based task force with the charge for plans toward reforming the current Medicare system to one that is properly financed, provides health care for those with well-qualified economic needs and places quality of care as a top priority; and, be it further

RESOLVED, that the Medical Association of Georgia delegates to the American Medical Association seek support from the American Medical Association at its annual meeting in June; and, be it further

RESOLVED, that all Georgia Senators and Representatives be so informed; and, be it further

RESOLVED, that the Medical Association of Georgia is unalterably opposed to further nationalization of our health care delivery systems.

#### **House Action**

Resolution was withdrawn from consideration.



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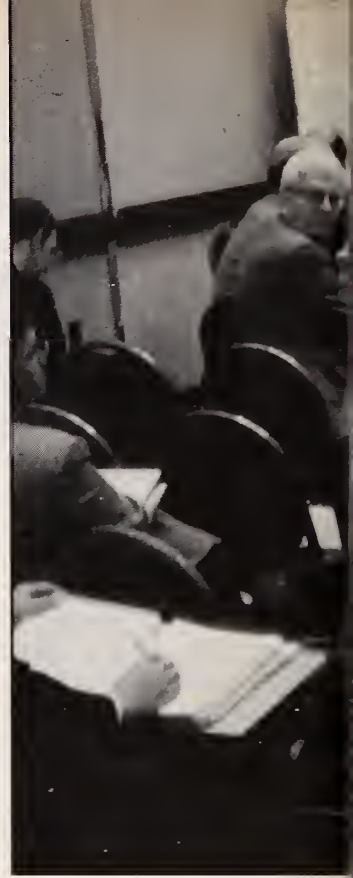


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# Report

## Reference Committee



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### PRESIDENT'S REPORT

**Jack F. Menendez, M.D.,  
President**

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**T**he following physicians were members of Reference Committee C: Teresa E. Clark, Chairman, Medical Association of Atlanta; Edmund M. Molnar, Vice Chairman, Muscogee; Cassius M. Stanley, III, Bibb; Charles W. McDowell, Jr., DeKalb; William Weston, III, Richmond; Joy A. Maxey, DeKalb; James F. Beattie, Jr., Walker-Catoosa-Dade; John S. Newton, Colquitt; and Gerald E. Sanders, Cobb.

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*Referred to: Rec. 1, 2 (a, b), 3, 4, 5 — Reference Committee D; Rec. 2 (c, d) — Reference Committee C; Rec. 6 — Reference Committee A; Rec. 7 — Reference Committee C.*

**R**efer to Report of Reference Committee A for the President's Report.

#### Recommendations

2.c. The President-Elect be Vice Chairman of the Legislative Committee and in charge of legislative education; and

d. The Immediate Past President be Vice Chairman of the Legislative Committee in charge of legislative events and *plan* the MAG legislative events, specifically the Legislative Seminar, the Physician Involvement Program (PIP), and the Doctor-of-the-Day Program,

7. That a proposal for legislative action removing professional liability from the courts be presented to the next House of Delegates meeting.

#### House Action

Adopted Recommendation 2c as amended: "At the President's discretion, the President-Elect be Vice Chairman of the Legislative Council in charge of legislative education, in consultation with the Council Chairman; and"

Adopted Recommendation 2d as amended: "At the President's discretion, the Immediate Past President be Vice Chairman of the Legislative Council in charge of legislative events, specifically the Legislative Seminar, the Physician Involvement Program, and the Doctor-of-the-Day Program, in consultation with Council Chairman."

Recommendation 7 was considered along with Rec. 3 of the Ad Hoc Committee for Tort Reform, and Rec. 1 of the First Vice President's report and adopted by deletion and substitution: "That this Committee, working through the Legislative Council at the direction of the Ex-





Members and guests of Reference Committee C listen to Georgia's attorney general, Michael Bowers.

ecutive Committee, strive for introduction and action on tort reform initiatives by the General Assembly during the 1989-90 term."

# FIRST VICE PRESIDENT

Joe L. Nettles, M.D.

*Referred to: Rec. 1 — Reference Committee C; Rec. 2 — Reference Committee D; Rec. 3 — Reference Committee A.*

See Report of Reference Committee A for the First Vice President's Report.

## Recommendation 1

Further legislative efforts should be pursued by MAG to obtain a cap on non-economic damages, even if this has to be done through other than traditional legislative reform in a lawyer-packed legislature. Recommendation 3 of the Ad Hoc Committee on Tort Reform, Rec-

ommendation 7 of the President's Report, and Recommendation 1 of the 1st Vice President were considered as a group and adopted by deletion and substitution: "That this Committee, working through the Legislative Council at the direction of the Executive Committee, strive for introduction and action on tort reform initiatives by the General Assembly during the 1989-90 term."

## House Action

See House Action for Recommendation 7 of the President's report immediately preceding.

# LEGISLATIVE COUNCIL

James A. Kaufmann, M.D.,  
Chairman

Major changes in the personnel of the MAG Legislative team and the greatest volume of medically related bills ever introduced in the General Assembly were just

two of the challenges that faced us this year. This report will discuss the success and the need for improvement in certain areas as we strive to become even more effective. **The most significant aspect of this report is the discussion outlining proposed improvements and their corresponding "Recommendations"** being presented for consideration by the House of Delegates.

## The Georgia General Assembly

The 1988 session of the General Assembly adjourned *sine die* at 10:32 P.M., March 7, ending a 40-day offensive against the physicians of Georgia by a wide variety of opponents. While our foes were tenacious and unrelenting, MAG did not suffer a major defeat all session, and had a string of victories and favorably negotiated bills to show for its strong effort on behalf of quality health care.

A cooperative effort by physicians and auxiliaries who participated in the Physician Involvement Program led the fight and were backed up by our legislative team at the Capitol. Legislators were very aware of the views of Georgia's phy-



sicians on the many issues that concerned them. It is this PERSONAL PHYSICIAN INVOLVEMENT that is, and always will be, the KEY to MAG's SUCCESS.

### **Among the Legislative Successes in 1988:**

1. Defeating the Kidd "Christmas tree" amendments and passing a "clean" version of the Omnibus Board Reauthorization bill (HB 1349);

2. Passing an informed consent bill which protects both physicians and patients (SB 367);

3. Passing a bill which establishes a system for regulating PPOs in Georgia which protects both participating and non-participating physicians (HB 507);

4. Passing a comprehensive AIDS policy for the state which gives physicians increased abilities to treat the disease, protection to notify other persons at risk, and allows confidentiality for victims of the disease without unduly burdening doctors and hospitals (HB 1281);

5. Defeating attempts by optometrists to become ophthalmologists. *For the first time*, optometrists are *prevented by law* from treating glaucoma. Optometrists are limited to the use of certain approved topical drugs and held to the same standard of care as physicians when using the drugs (HB 1169);

6. Defeating an attempt to mandate third party reimbursement for advanced practice nurses (HB 334);

7. Defeating an attempt by physical therapists to practice independently (SB 292);

8. Defeating an attempt by physician's assistants to practice with inadequate physician supervision (SB 499);

9. Defeating an attempt by counselors and marriage and family therapists to have their communications with clients put on the same level of confidentiality as psychiatrists and their patients (HB 393);

10. Defeating attempts by chiropractors to use techniques that

are invasive of the body's orifices, to delete the physicians' standard of care language and delete the language in current law that prohibits them from using drugs or performing surgery (SB 443); Chiropractors will be allowed to recommend the use of vitamins, minerals, or food substances under certain circumstances while not receiving *any* profit from the sale of such substances (HB 1243);

11. Passing a mandatory seat belt bill (HB 751) and tightening the child restraint law (HB 71);

12. Passing a voluntary child and adolescent drug screening program modeled after the Cobb Medical Society Program (SB 641).

### **Successful, But Still Room for Improvement: Restructuring and Improving the Legislative Council**

The many successes of this past session are the direct result of the individual participation in the political process by YOU and other physicians. Each of you who contributed to GAMPAC, wrote a legislator, met personally with your Senator or Representative, participated in the Physician Involvement Program (PIP) or made calls to the Capitol are to be commended and congratulated for a "job well done!"

Last year's Legislative Council's report stated in part: "The legislative session of 1987, more so than any previous year, was busier and much more confusing than any other session." The 1988 session was a real "barn burner" that exceeded last year. Never has the Medical Association had so many legislative matters thrown at them and by such a determined opposition.

Thanks to the almost 24 hours a day effort of our legislative staff, *we did not lose a single issue of significance*. Special mention must be made of the efforts of our legislative team. Mike Fowler, our Executive Director, devoted many hours each day helping stem the tide and win

the day. Richard Greene, our General Counsel, worked until late at night and into the early hours of the morning in skillfully crafting legislative bills and modifying others. Scott Mall, who although on board for only one month as our Legislative Relations Director, was an effective advocate and did a brilliant job of producing the "Legislative Bulletin." Words cannot express the appreciation we owe Paul Shanor, our Legislative Counsel, who also burned the midnight oil for you and frequently demonstrated his great knowledge of health issues. Donna Glass, secretary to our Legislative team, worked long hours and weekends manning the home front at MAG headquarters while the staff was more than busy at the Capitol.

All of this work would have been for naught if it had not been for the help of the MAG Officers including Jack F. Menendez, Joe P. Bailey, Ralph A. Tillman, Joe L. Nettles, Bill C. Collins, Frank F. Middleton, III, Charles R. Underwood, John D. Watson, Richard W. Cohen, Cyler D. Garner, and Jack A. Raines. Even more important, as previously stated, are the many MAG members that back up our "team."

All of this increased activity made it very clear that there is a need to significantly increase the active participation of the Legislative Council. It is felt that each specialty society and other recognized specialty practitioner groups should have a representative on the Legislative Council. Each such group should also have an alternate who will be available to attend meetings if the designated physician is unable to attend. Increased specialty representation should lead to a better and more effective Legislative Council and a more unified medical lobby effort. Other individual physicians should be appointed who show a desire and willingness to attend to the business of the Council, but no one should agree to serve unless they are totally committed to attend to the business of



the Council, and to regularly attend the meetings.

It is also felt that the Legislative Council would be improved by more frequent meetings. Regularly scheduled meetings every six weeks need to be held to enable the Council to remain current and prepared on medical issues. The issues are more complex and numerous today; therefore, an active Legislative Council is needed now more than ever before. Even more importantly, Council members need to be current to direct and inform the members of their constituent organizations and county medical societies to keep an effective liaison with the members and legislators. The political arena is known for being fluid. A well informed and better prepared Legislative Council will be a more effective Council. The speed with which complex issues on both the state and federal levels change is tremendous, and more frequent meetings will help us remain in control of the situations as they develop.

This is especially true for 1988 as this is an election year. Your Legislative Council needs to be an active participant in campaign considerations. This is also the time when interim legislative committees hold statewide public hearings. Most legislation is won or lost during the interim period and not during the session. Of course, the Congress and Federal Bureaucrats never give us time to rest.

During the session of the General Assembly, the Council should meet at MAG headquarters each Friday afternoon after the weekend adjournment. Many key decisions are being made as the session progresses. The membership should be more involved in these day to day decisions. These weekly meetings will enable more input to and advice for our legislative team. These meetings should last only for one to two hours and they would not conflict with the legislature by waiting until after the Friday noon

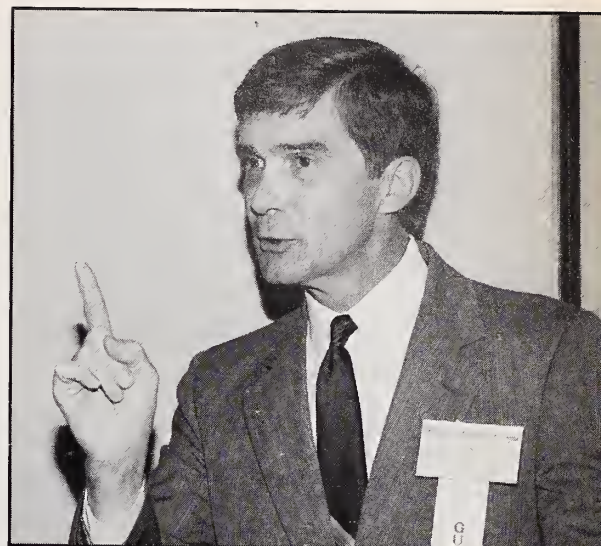
adjournment; therefore, giving Council members the opportunity to contact their medical constituents and legislators over the weekend. Also, strong emphasis should be placed upon securing members to the Council who will dedicate themselves to attending virtually every meeting and be willing to place the necessary effort, study and commitment to being a productive member.

## Groups Working Together

Some specialty groups have considered, or even had introduced, legislation to meet certain needs or goals of that particular group. Even some individual physicians acting virtually alone have had bills introduced. While continuing to recognize the rights of any group or individual to act independently, it is generally recognized that a unified and united medical lobby will become more effective than if divided; therefore, persons or groups considering the introduction of legislation are strongly urged and encouraged to submit such proposals to the Legislative Council for consideration, comparison to MAG policy, and discussion prior to its being introduced. Likewise, whenever such persons or groups are contemplating or have already hired independent lobbyists or "consultants" they are also strongly urged and encouraged to discuss such with the Legislative Council prior to making such a decision. It needs to be clearly understood that neither request for "consultation" is designed to prevent any group or person from taking whatever action they feel is appropriate. The Georgia Society of Anesthesiologists, Inc. is especially to be commended for instructing its independent lobbyist to work closely and directly with and under the guidance of MAG's lobbying effort. Remember, "united we stand, divided we fall!"

## Campaign '88

This is an election year, and YOU



*Michael Bowers, Georgia's attorney general, spoke to members of Reference Committee about the diversion of legitimate prescription drugs and the multi-copy (triple script) bill before the General Assembly.*

are STRONGLY URGED to actively participate in and contribute to the campaigns of the candidates of your choice and to contribute to GAM-PAC as well. Legislators are appreciative of financial contributions; however, they are even more thrilled to get campaign workers. Participate by serving on a campaign committee, help raise funds by contacting fellow physicians, put up signs at your office, volunteer your phones for night time phone banks or offer for you and your staff to make calls on the candidate's behalf.

## The PIP and Doctor of the Day

We need to improve the PIP program and increase physician involvement. PIP is now six years old and there appears to be a need to reorganize the program. Special emphasis should be placed on encouraging the participation of physicians who have not been involved. Physicians are encouraged to bring their spouse, which, in turn, will help stimulate auxiliary participation. The Legislative Council will be conducting a comprehensive study of ways to improve and invigorate PIP.

1988 saw another successful Doctor of the Day Program. MAG



members provided medical care to all persons at the Capitol through this very popular program. 1988 also saw Mrs. Veronica Brame as the new Medical Aid Station nurse. Mrs. Brame served full-time during the session and received well-deserved praise from Legislators, Capitol staffers and from the general public. Thanks Veronica!

### Thanks to Many for So Much

"Thanks" is inadequate to express the necessary appreciation for the legislative effort of the Auxiliary. Not only did they work on their specific issues such as mandatory seat belts and improved child restraint laws, they also enthusiastically supported MAG issues. They also organized and operated an active and effective telephone bank. Plans are presently being developed for an even better telephone bank next year.

We would also be remiss if we didn't thank another important group. A grateful "thank you" is extended to the MAG Mutual Insurance Company for their tireless support and assistance this year. Special thanks to Dr. Charles Hollis, Chief Executive Officer; Mr. Tom Gose, President, Rachael Siegelman, Staff Attorney, and Robert Constantine, Corporate Attorney, for their unselfish and dedicated service.

### Recommendations

I have some very important recommendations to propose that I have thoughtfully considered (some for many years) that are as follows:

1. That the Legislative Council be expanded by having each recognized specialty society or group nominate one voting representative and one alternate who would be able to give input at each meeting of the Legislative Council. Strong efforts would be made to ensure that every such specialty society is actually represented at each and every meeting; thereby guaranteeing their proper voice of representation.

Consideration would be given for larger societies to have greater representation.

2. That meetings of the Legislative Council be held at 6-week intervals except during the legislative session when they would be held each Friday afternoon after the adjournment for the weekend.

3. That the Legislative Council conduct a thorough review of PIP in order to revitalize the program, improve physician and spouse participation, and to have a greater impact on the legislative process.

4. That the Legislative Council be composed of members who are committed to serving MAG and the Council by attending and working at the Capitol during the General Assembly.

5. That specialty groups and individual physicians be encouraged to submit any proposed legislation to the Legislative Council prior to its introduction.

6. That specialty groups be encouraged to consult with Legislative Council prior to hiring independent lobbyists or consultants.

7. That individual MAG members and their spouses be encouraged to not only contribute to GAM-PAC, but more importantly to personally participate in legislative campaigns this election year.

8. That MAG members make themselves, their staffs and their office equipment (i.e. telephones, copiers, printers, computers) available to help the candidates of their choice.

9. That Mrs. Cherie Dennis, Mrs. Maureen Vandiver, Mrs. Jan Collins, Mrs. Mary Agraz, and the many Auxiliary volunteers be commended for the successful 1988 telephone bank.

10. That MAG staff, Legislative Council, and the Auxiliary work together to develop and improve the effectiveness of the telephone bank for 1989, and that all members of the Auxiliary who participated as a telephone bank volunteer be written a thank you letter by the Leg-

islative Council Chairman.

11. That Dr. Charles Hollis and MAG Mutual Insurance Company be commended for going above and beyond the call of duty by its effective assistance during the General Assembly.

**Please read the discussion that precedes these recommendations carefully to evaluate the need for them, particularly the section on page 3 entitled "Successful, But Still Room for Improvement: Restructuring and Improving the Legislative Council."**

I appreciate the opportunity to serve the organization that I so dearly love.

If you desire details of all major bills considered, copies of our final Legislative Bulletin are available.

### House Action

Adopted Recommendation 1.

Adopted Recommendation 2 as amended: "That meetings of the Legislative Council be held as directed by the Chairman as often as necessary during the legislative session and regularly throughout the year."

Adopted Recommendation 3.

Adopted Recommendation 4.

Adopted Recommendation 5 as amended: "That specialty groups and individual physicians be encouraged to discuss any proposed legislation with the Legislative Council prior to its introduction."

Recommendation 6 and Resolution 22 were considered together and adopted by deletion and substitution: "That specialty groups be encouraged to consult with the Legislative Council prior to hiring independent lobbyists or consultants, and such lobbyists or consultants be encouraged to work with MAG legislative staff for better coordination of efforts."

Adopted Recommendation 7 as amended: "That individual MAG members and their spouses be encouraged to not only contribute to GAM-PAC, but more importantly, to personally participate in legislative



campaigns."

Adopted Recommendations 8, 9, 10, and 11.

### PHYSICIAN-LAWYER LIAISON

**James A. Kaufmann, Jr.,  
M.D., Chairman**

The MAG Committee on Physician-Lawyer Liaison is charged with the responsibility of overseeing the inter-relationship between physicians and lawyers, and their respective state professional associations, in Georgia.

Although there were no scheduled meetings during 1987-1988, the charge of the Liaison was carried out through staff meetings of both MAG and the State Bar. It is felt that the role of the Liaison will increase because better relations between the two professions need to be augmented. The last several years' political skirmishes involving tort reform created unnecessary tensions with some sub-groups within the legal profession. With our Committee's efforts we hope to ease this tension and improve those relationships.

We continue to work with the State Bar Association on a revision of the "Principles Governing Physician-Attorney Relationships" pamphlet. Negotiations have continued with MAG General Counsel and counsel for the State Bar Association to finalize this important project. A finalized version should be presented to the MAG Board of Directors for approval at its June meeting.

#### Recommendations

1. That the "Principles" pamphlet be distributed to MAG members upon its adoption by both MAG and the State Bar Association.

2. That the Physician-Lawyer Liaison Committee continue to meet

both independently of and jointly with the State Bar Association's corresponding committee to discuss issues of mutual concern.

3. That the Physician-Lawyer Liaison Committee serve as the MAG component to a joint MAG-State Bar Association committee to resolve disputes between individual physicians and attorneys.

#### House Action

Adopted Recommendation 1 as amended: "That the 'Principles' pamphlet be distributed to MAG members upon its adoption by both the MAG Board of Directors and the State Bar Association.

Adopted Recommendations 2 and 3.



*Dr. Teresa Clark, Chairman of Reference Committee C, speaks to MAG's Speaker of the House, James Kaufmann.*

### PUBLIC HEALTH COMMITTEE

**Gray Rawls, M.D.,  
Chairman**

*Referred to: Rec. 1 — Reference Committee C; Rec. 2 — Reference Committee A.*

See Report of Reference Committee A for Public Health Committee Report.

#### Recommendations

1. The Public Health Committee recommends that the MAG support

the development of a physician's clinical protocol for AIDS and HIV infection which emphasizes clinically-relevant information, appropriate assessment, and patient counseling. The purpose being to enhance the success of public health efforts to prevent AIDS by the integration of HIV assessment and counseling in the clinician's daily practice of medicine.

#### House Action

Adopted Recommendation 1 as amended: "That the Medical Association of Georgia recommends that its members continue to seek information on AIDS relevant to their daily practice to enhance the suc-



cess of public health efforts to prevent AIDS."

See Public Health Committee report in Report of Reference Committee A for Recommendation 2 and that House Action.

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### THIRD PARTY PAYORS COMMITTEE

**C. Peter Lampros, M.D.,  
Chairman**

*Referred to: Rec. 1, 2, 3 —  
Reference Committee B; Rec.  
4 — Reference Committee C.*

**S**ee Report of Reference Committee B for Third Party Payors Committee report and Rec. 1, 2, 3.

#### Recommendation

4. That the MAG seek enactment of Georgia statutes creating PRO and payor liability for patient harm incurred as a result of unreasonable or negligent application of requirements for prior or continuing approval of medical, surgical or hospital care.

#### House Action

Referred to the Board of Directors for study.

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### AD HOC COMMITTEE TO STUDY ALTERNATIVES TO TORT REFORM

**Hugo S. Moreno, M.D.,  
Chairman**

**T**his Committee was created at the 1987 MAG House of Delegates and charged to seek alternative means to properly and expeditiously compensate the deserving

medically injured patient and/or family and to report its findings and/or recommendations to the Executive Committee by November 1987.

Our Committee met twice last year. It received voluminous material from the MAG staff explaining the different approaches and solutions proposed and sometimes put into effect by several states and/or organizations, such as the binding arbitration type, the no fault worker's compensation type, the brain damaged child law, etc. One interesting proposal was submitted by a former lawyer who has devised and applied a system of binding arbitration in several businesses and industries and wanted to apply it to the practice of medicine. However such a system seems too cumbersome.

The AMA, as is well known, unveiled a specific, well researched and possible effective solution to the malpractice crisis last January 13, but it has not been adopted yet by any state. AMA is trying to find a state where laws could be changed to make this approach possible.

At a special meeting of its General Assembly, the State of Florida passed a very interesting and favorable malpractice law that might be used as a guideline if the constitutionality of such a law is sustained by the courts.

All of the above information proves the complexity of the problem and the need for prolonged and detailed research before MAG may take a definitive course of action.

#### Recommendation

That these studies of the Ad Hoc Committee to Study Alternatives to Tort Reform be continued by either the Legislative Council or an already existing Ad Hoc Committee with the understanding that the cooperation of Consumer groups, legislators and the Composite State Board of Medical Examiners is necessary.

#### House Action

Combined this Recommendation with Recommendation 1 of the Ad Hoc Committee for Tort Reform to be adopted as amended:

"That the studies of the Ad Hoc Committee to Study Alternatives to Tort Reform be continued by the Ad Hoc Committee for Tort Reform and that the Ad Hoc Committee for Tort Reform incorporate the goals of the Ad Hoc Committee to Study Alternatives to Tort Reform."

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### AD HOC COMMITTEE ON DIVERSION OF LEGITIMATE PRESCRIPTION DRUGS

**Milton I. Johnson, Jr.,  
M.D., Chairman**

**T**his Ad Hoc Committee was charged to work with the State Board of Pharmacy, the Georgia Pharmaceutical Association, the Composite State Board of Medical Examiners, and representatives of the Georgia Bureau of Investigation (GBI) to draft model legislation acceptable to all involved groups, to consider solutions to the problem of diversion of legitimate prescription drugs and to insure protection of both the rights of physicians and patients. Our Committee has now completed its charge.

The Committee was reactivated by President Jack F. Menendez during the autumn of 1987 after a request was made by Mr. Michael J. Bowers, Attorney General of Georgia, for MAG's help in what he found to be a continuing severe problem.

The Committee met on October 8, 1987 at which time Attorney General Bowers, Mr. J. Robert Hamrick, GBI Director, and Mr. James L. Baker, Squad Commander from the Georgia Bureau of Investigation, and



Ms. Cheri Baglin, investigator for the Drug Enforcement Administration made presentations concerning the scope of the drug diversion problem.

The Committee considered many facets of the problem and decided to hold an additional meeting for the purpose of hearing from representatives of pharmaceutical manufacturers concerning alternate solutions to the problem other than the "Triplicate Prescription Blank Program." It was also decided to try to rewrite the previously drawn bill, addressing the previously expressed concerns of the Committee, the MAG Board of Directors, prior reference committee and the House of Delegates.

The Committee met again in a lengthy session on December 20, 1987 hearing several presentations in opposition to the Triplicate Prescription Blank Program, and the outlining of possible alternate solutions from three pharmaceutical company representatives led by Mr. Guy Mosier of the E. I. DuPont DeNemours & Company.

The Committee proceeded to rewrite the previously proposed Triplicate Prescription Blank Program bill with advice from MAG General Counsel, Richard Greene. The provision of the original bill requiring physicians to keep a copy of the prescriptions on file for two (2) years has been replaced with language allowing the physician to merely make a notation of the prescription in the patient's medical record.

The Committee reported to the January meeting of the Board of Directors at which time Attorney General Bowers discussed the magnitude of the problem of diversion of legitimate prescription drugs in Georgia at considerable length. He asked that MAG sponsor a bill to set up a Triplicate Prescription Blank Program for Class II drugs in Georgia. A lengthy question and answer period followed and, subsequently, the Board voted to refer this

proposal to the MAG House of Delegates for further consideration and action.

I wish to thank all the members of the Ad Hoc Committee on Diversion of Legitimate Prescription Drugs for their time and effort to this Committee. Our Committee submits the following recommendations for consideration by the House of Delegates:

## Recommendations

1. That the MAG House of Delegates consider supporting a prescription blank program as an appropriate method of dealing with the diversion of legitimate prescription drugs.

2. That MAG consider endorsing the rewritten version of this bill for legislative action in the 1989 Georgia General Assembly.

## House Action

Adopted both Recommendations.

# ATTACHMENT

## Ad Hoc Committee on Diversion of Legitimate Prescription Drugs

Note to reader:

Section 1 is the current law. The struck through language is current law that is being deleted. The underlined language is the new proposed version.

Section 2 is a new proposed law. The struck through language was in the earlier version of this bill. The underlined language has been added this year by the Committee.

\* \* \*

## A BILL TO BE ENTITLED AN ACT

To amend Chapter 13 of Title 16 of the Official Code of Georgia Annotated, relating to controlled substances, so as to provide for a pre-

scription form program for the prescribing of Schedule II controlled substances; to provide for exceptions and requirements and procedures relating thereto; to provide limitations upon filling prescriptions for Schedule II narcotic drugs; to provide for forms, their content, and procedures relating thereto; to provide for return and forfeiture of forms; to limit access to information contained on forms, provide for a system to process such information, and provide for the use of such information; to provide for the purging of certain information and audits, reports, and disciplinary actions relating thereto; to provide for rules; to provide for annual reports; to provide that certain conduct is unlawful and provide penalties therefor; to provide for effective dates and automatic repeal; to repeal conflicting laws; and for other purposes.

*Be it enacted by the General Assembly of Georgia:*

*Section 1.* Chapter 13 of Title 16 of the Official Code of Georgia Annotated, relating to controlled substances, is amended by striking Code Section 16-13-41, relating to prescriptions, and inserting in its place a new Code Section to read as follows:

"16-13-41. (a) ~~Except when dispensed directly by a registered practitioner, other than a pharmacy or pharmacist, to an ultimate user~~ Except as otherwise provided in this Code section, no controlled substance in Schedule II may be dispensed without the written prescription of a registered petitioner on a form that meets the requirements of and is filled in by the practitioner in accordance with Code Section 16-13-41.1.

~~(b) When a registered practitioner writes a prescription to cause the dispensing of a Schedule II substance, he shall include the name and address of the person for whom it is prescribed, the kind and quantity of such Schedule II controlled~~



~~substance, the directions for taking the signature, and the name, address, and federal registration number of the prescribing practitioner. Such prescriptions shall be signed and dated by the prescribing practitioner on the date when issued.~~

(b) A prescription for a controlled substance in Schedule II and written for a patient who is admitted to a hospital at the time the prescription is written and filled is not required to be on a form that meets the requirements of Code Section 16-13-41.1 and the provision of Code Section 16-31-41.1 are not applicable to such prescriptions.

~~(c) In emergency situations, as defined by rule of the State of Pharmacy, Schedule II drugs may be dispensed upon oral prescription of a registered practitioner, reduced promptly to writing and filed by the pharmacy. Prescriptions shall be retained in conformity with the requirements of Code Section 16-13-39., which~~

(c) Schedule II drugs may be dispensed by a pharmacist in emergency situations upon oral prescription of a licensed practitioner, which is promptly reduced to writing by the pharmacist and shall include in the dispensing pharmacy's written record of the oral prescription the name, address, and federal drug enforcement administration number of the prescribing practitioner, all information required to be provided by the practitioner under paragraph (1) of subsection (c) of Code Section 16-31-41.1. and all information required to be provided by the dispensing pharmacist under subsection (e) of Code Section 16-31-41.1.; and the dispensing pharmacy shall send a copy of the written record to the Composite State Board of Medical Examiners within 30 days from the date the prescription is filled and retain the original record for a period of not less than two years. A registered practitioner may issue an oral prescription in an emergency situation in accordance with the conditions

as may be defined and required by the State Board or agency that issues the practitioner's license. No prescription for a Schedule II substance may be refilled.

(d) (1) Except when dispensed directly by a practitioner, other than a pharmacy or pharmacists, to an ultimate user, a controlled substance included in Schedule III, IV, or V, which is a prescription drug as determined under any law of this state or the federal Food, Drug and Cosmetic Act, 21 U.S.C. Section 301, 52 Stat. 1040 (1938). shall not be dispensed without a written or oral prescription of a registered practitioner. The prescription shall not be filled or refilled more than six months after the date on which such prescription was issued or be refilled more than five times.

(2) When a registered practitioner writes a prescription to cause the dispensing of a Schedule III, IV, or V controlled substance, he shall include the name and address of the person for whom it is prescribed, the kind and quantity of such controlled substance, the direction of taking, the signature, and the name, address, and federal registration number of the prescribing practitioner. Such prescriptions shall be signed and dated by the prescribing practitioner. Such prescriptions shall be signed and dated by the prescribed practitioner on the date when issued.

(e) A controlled substance included in Schedule V shall not be distributed or dispensed other than for a legitimate medical purpose.

(f) No person shall prescribe or order the dispensing of a controlled substance, except a registered practitioner who is:

- (1) Licensed or otherwise authorized by this state to prescribe controlled substances;
- (2) Acting in the usual course of his professional practice; and
- (3) Prescribing or ordering such controlled substances for a legitimate medical purpose.

(g) No person shall fill or dispense a prescription for a controlled substance except a person who is licensed by this state as a pharmacist or a pharmacy intern acting under the immediate and direct personal supervision of a licensed pharmacist in a pharmacy licensed by the State Board of Pharmacy, provided that this subsection shall not prohibit a licensed physician, dentist, veterinarian, or other registered practitioner authorized by this state to dispense controlled substances as provided in this article if such licensed person complies with all record-keeping, labeling package, and storage requirements regarding such controlled substances and imposed upon pharmacists and pharmacies in this Chapter and in Chapter 4 of Title 26 and complies with the requirements of Code Section 26-4-4.

(h) It shall be unlawful for any practitioner to issue any prescribed document signed in blank. The issuance of such document signed in blank shall be prima-facie evidence of a conspiracy to violate this article. The possession of a prescription document signed in blank by a person other than the person whose signature appears thereon shall be prima-facie evidence of a conspiracy between the possessor and the signer to violate the provisions of this article.

(i) No prescription for Schedule II narcotic drugs shall be filled after the end of the third day following the day on which the prescription was issued."

Section 2. Said Chapter is further amended by adding a new Code Section following Code Section 16-13-41 to read as follows:

"16-31-41.1. (a) There shall be formed as a separate division of the Composite State Board of Medical Examiners a 'Stop the Diversion of Prescription Drugs Advisory Committee.' The Advisory Committee shall administer and develop the prescription form required by this Act, and provide for the distribution



of those forms. The Advisory Committee shall consist of 11 members, 3 shall be M.D.s licensed by the Composite State Board of Medical Examiners, 2 shall be licensed dentists, 2 shall be licensed veterinarians, 2 shall be licensed podiatrists, 2 which shall be licensed pharmacists. The Chairman shall be a licensed M.D.

(b) As used in this Code Section, the term 'GBI' means the Georgia Bureau of Investigation. Except as otherwise provided in Code Section 16-13-41, each prescription for a controlled substance in Schedule II must be recorded on a prescription form that meets the requirements of subsection (c) of this Code section and that is issued to practitioners at no cost by the GBI state board or agency that issues the practitioner's license. No more than one such prescription shall be recorded on each form. Before delivering forms to a practitioner, the GBI "Stop the Diversion of Prescription Drugs Advisory Committee" shall have printed on the forms the name, address, and federal drug enforcement administration number of the practitioner. For administrative purposes individual boards shall consolidate the printing and distribution of the forms through the Composite State Board of Medical Examiners and the Stop the Diversion of Prescription Drugs Advisory Committee.

(c) Each prescription form required to be used under subsection (b) of this Code section shall be serially numbered and in triplicate, with the original copy labeled 'Copy 1,' the duplicate copy labeled 'Copy 2,' and the triplicate copy labeled 'Copy 3.' Each form must contain spaces for:

- (1) The date the prescription is written;
- (2) The date the prescription is filled;
- (3) The drug prescribed, the dosage, and instruction for use;
- (4) The name, address, and federal drug enforcement administration

number of the dispensing pharmacy and the name of the pharmacist who fills the prescription; and

- (5) The name, address and age of the person, or in the case of an animal, its owner, for whom the controlled substance is prescribed.

(d) Except for oral prescriptions prescribed under subsection (c) of Code Section 16-13-41, the prescribing practitioner shall:

- (1) Fill in on all three copies of the form in the space provided:
  - (A) The date the prescription is written;
  - (B) The drug prescribed, the dosage, and instructions for use; and
  - (C) The name, address and age of the patient or, in the case of an animal, its owner, for whom the controlled substance is prescribed;

- (2) Sign Copies 1 and 2 of the forms and give them to the person authorized to receive the prescription; and

- ~~(3) Retain Copy 3 of the form with the practitioner's records for a period of not less than two years from the date the prescription is written.~~

- (3) The registered practitioner may retain Copy 3 of the form with the practitioner's records of the patient or make a notation within the patient's records of the prescription including the date the prescription is written, the drug prescribed and the dosage which shall be maintained for at least 2 years from the date the prescription is written.

(e) In the case of an oral prescription prescribed under subsection (c) of Code Section 16-13-41, the prescribing practitioner shall give the dispensing pharmacy the information it needs to complete the written record required to be sent to the GBI "Composite State Board of Medical Examiners" under that subsection (c).

(f) Each dispensing pharmacist or practitioner shall:

- (1) Fill in on Copies 1 and 2 of the form in the space provided the information not required to be filled in by the prescribing practitioner ~~or the GBI~~.

- (2) Retain Copy 2 with the records of the dispensing pharmacy or practitioner for a period of not less than two years; and

- (3) Sign Copy 1 and send it to the GBI Composite State Board of Medical Examiners within 30 days from the date the prescription is filled.

(g) A practitioner in possession of prescription forms issued under this Code section whose license to practice or federal drug enforcement administration number is suspended or revoked shall, within seven days after the suspension or revocation becomes effective, return to the GBI Composite State Board of Medical Examiners all of such forms which have not been used to issue prescriptions.

(h) The Executive Director of the GBI Composite State Board of Medical Examiners nor any other person shall not permit access to information submitted to the GBI Composite State Board of Medical Examiners pursuant to this Code section to any person except:

- (1) Investigators for the Georgia Composite State Board of Medical Examiners, the Georgia State Board of Podiatry Examiners, the Georgia Board of Dentistry, the Georgia State Board of Pharmacy and ~~(2)~~ authorized officers of the GBI engaged in a bona fide investigation of suspected criminal violations of this chapter, may obtain such access only with the approval of and upon specific authorization of the licensing board of the person to be investigated which authorization will be for a specifically stated investigation and purpose. Such access shall also require the approval of a li-



censed medical doctor who is the Medical Coordinator of the Composite State Board of Medical Examiners after he reviews the investigation file which forms the basis of the request and determines that the investigation is meritorious. Access by such officers and investigators shall take place only in the actual presence of the Medical Coordinator; or (3) ~~Officers or Employees of the GBI "Composite State Board of Medical Examiners"~~ who are required to receive or process the information submitted pursuant to this Code section.

(i) The system for retrieval of information submitted to the GBI "Composite State Board of Medical Examiners" pursuant to this Code section shall be designed in all respects so as to preclude improper access to information through use of automated information security techniques and devices "or by any other improper means." The Executive Director of the GBI "Composite State Board of Medical Examiners" shall submit the system design to the State Board of Pharmacy and the Georgia Composite State Board of Medical Examiners for review, comment and approval in reasonable time before implementation of the system and shall comply with the comments of those boards unless it would be unreasonable to do so, but shall not implement said system without approval of said boards. The Georgia Composite State Board of Medical Examiners and the State Board of Pharmacy shall promptly review, comment and consider approval ~~approve or comment on~~ of the system design submitted by the Executive Director.

(j) Information submitted to the GBI "Composite State Board of Medical Examiners" pursuant to this Code section shall be used only for bona fide drug-related criminal investigatory or eviden-

tiary purposes or for investigatory or evidentiary purposes in connection with the functions of one or more of the licensing boards listed in paragraph (1) of subsection (h) of this Code section.

(k) Each identity of an individual which is submitted to the GBI "State Board of Medical Examiners" pursuant to this Code section shall be removed from the system for retrieval of such information and shall be destroyed and rendered irretrievable not later than the end of the sixth calendar month following the month in which such identity was submitted to the GBI "State Board of Medical Examiners," provided that an individual identity which is necessary for use in a specific ongoing investigation conducted in accordance with this Code section may be retained in the system until the end of the month in which the necessity for retention of such identity ends. The GBI "Composite State Board of Medical Examiners" shall issue a report at least quarterly to the Governor certifying that the provisions of this subsection have been complied with and setting forth in detail the results of quarterly audits by the state auditor showing that identities have been removed from the system and rendered irretrievable in compliance with this subsection. Failure to comply with any provisions of this subsection shall be corrected as soon as practicable after discovery, and any person responsible for failure to comply with this subsection shall be subject to disciplinary action for such failure, including but not limited to dismissal.

(1) ~~The Director of the GBI "Composite State Board of Medical Examiners"~~ may promulgate rules to implement this Code Section and Code Section 16-13-41.

(m) On or before January 1 of each year, beginning in 1989, the Georgia Composite State Board of Medical Examiners, the Georgia State Board of Podiatry Examiners, the Georgia Board of Dentistry, the

Georgia State Board of Veterinary Medicine, the Georgia State Board of Pharmacy, and the GBI shall jointly submit a public report to the Governor and the General Assembly on the effectiveness of the triplicate program established pursuant to this Code Section and Code Section 16-13-41. Such report shall include for the most recently ended fiscal year:

- (1) The number of triplicate prescription blanks issued;
- (2) The number of lost or stolen triplicate prescription blanks;
- (3) The number of indictments, convictions, and peer review proceedings attributable to the triplicate program;
- (4) The cost of administering the program; and
- (5) Such other information as the reporting agencies shall deem appropriate.

(n) It is unlawful for any person intentionally or knowingly to give, permit, or obtain unauthorized access to information submitted to the GBI "Composite State Board of Medical Examiners" under this Code section, and any person who violates this subsection is guilty of a felony and, upon conviction thereof, may be imprisoned for not more than three years, fined not more than \$15,000.00, or both."

*Section 3.* Said chapter is further amended by striking from paragraph (4) of subsection (a) of Code Section 16-13-42, relating to unauthorized conduct and penalties relating to controlled substances, the following:

"; or",

and inserting in its place a semicolon, by striking the period at the end of the paragraph (5) of said subsection and inserting in its place the following:

"; or",

and by adding at the end of a new paragraph (6) to read as follows:

"(6) To refuse or fail to return triplicate prescription forms as required by subsection (g) of Code Section 16-13-41.1."



*Section 4.* Said Chapter is further amended by striking from the end of paragraph (6) of subsection (a) of Code Section 16-13-49, relating to items subject to forfeiture, and following:

“; and”,  
and inserting in its place a semicolon, by striking the period at the end of paragraph (7) of that subsection and inserting in its place the following:

“; and”,  
and by adding at the end of a new paragraph (8) to read as follows:

“(8) Prescription forms required by Code Section 16-13-41.1 to be returned to the ~~Georgia Bureau of Investigation~~ Composite State Board of Medical Examiners.”

*Section 5.* Code Section 50-18-72 of the Official Code of Georgia Annotated, relating to exemptions from disclosure for certain records, is amended by adding at the end thereof a new subsection to read as follows:

“(c) This article shall not be applicable to information contained on or derived from prescription forms or prescription reports filed with the ~~Georgia Bureau of Investigation~~ Composite State Board of Medical Examiners pursuant to the Code Section 16-13-41 or 16-13-41.1.”

*Section 6.* This Act shall not become effective unless O.C.G.A. 43-1-7 is amended as to provide that the direct and indirect cost of implementing this Act is not recouped through fees collected from the affected licensing and examining Boards.

*Section 7.* This Act shall become effective only upon the necessary appropriations being specifically allocated by the General Assembly to fund this Act; provided however that in no event shall this Act become effective prior to January 1, 1990.

*Section 8.* In the event that any section of this Act shall be held by a court of competent jurisdiction to be invalid, then the entire Act shall

be automatically repealed.

*Section 9.* This Act shall become effective for administrative purposes, including but not limited to promulgation of rules and distribution of forms, upon its approval by the Governor or upon its becoming law without that approval and shall become effective for all other purposes on January 1, 1990. This Act shall be automatically repealed July 1, 1993.

*Section 10.* All laws and parts of laws in conflict with this Act are repealed.

### AD HOC COMMITTEE ON MEDICAL CARE FOR THE DISADVANTAGED

**John Rhodes Haverty,  
M.D., Chairman**

*Referred to: Rec. 1, 3 — Reference Committee A; Rec. 2 — Reference Committee C.*

**S**ee Report of Reference Committee A for report of the Ad Hoc Committee on Medical Care for the Disadvantaged and Rec. 1 and 3.

#### Recommendation

2. That MAG continue to press for Georgia legislative and gubernatorial action concerning health care for the disadvantaged.

#### House Action

This Recommendation was considered with Resolution 23 and they were both adopted by deletion and substitution: “That MAG continue to press for Georgia legislative and gubernatorial action concerning health care for the disadvantaged, and encourage increased state funding for hospitals with significant populations of indigent patients.”

### AD HOC COMMITTEE ON PHYSICIAN DISPENSING & DRUGS

**Richard A. Wherry, M.D.,  
Chairman**

*Referred to: Rec. 1, 2 — Reference Committee D; Rec. 3, 4 — Reference Committee C.*

**T**he Committee met several times during 1987 to discuss both physician dispensing and generic drugs. Because of the State Board of Pharmacy's hearings on changing previous rules and regulations concerning physicians, primary emphasis was placed on physician dispensing. Based on reports presented to the Committee and information presented at the MAG Leadership Conference in January, 1988, the Committee recommends that the following be the Medical Association of Georgia's position on physician dispensing.

The Committee would like to thank MAG staff, particularly Donna Glass and Richard Greene for their assistance.

#### Recommendations

1. Physicians should maintain the right to dispense medications. Guidelines and recommendations of the American Medical Association's Committee on Ethical and Judicial Affairs must be considered by those physicians who choose to dispense. A physician's decision to dispense medications should be based on potential improvements to patient care, not on financial considerations.

2. MAG should help insure that medical students, residents and practicing physicians continue to be educated in the prescribing and dispensing of medications.



3. MAG should keep state and federal lawmakers aware of the appropriateness of this facet of patient care.

4. MAG should offer and support legislation which would make the Composite State Board of Medical Examiners responsible for overseeing the practice of physician dispensing instead of the State Board of Pharmacy.

### House Action

Adopted Recommendation 3.

Referred Recommendation 4 to the Board of Directors for action.

See Report of Reference Committee for House Action on Rec. 1 and 2.

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## AD HOC COMMITTEE FOR TORT REFORM

**John D. Watson, Jr., M.D.,  
Chairman**

**O**ur Committee was charged to coordinate and direct MAG's effort for passage of meaningful tort reform legislation under direction of the MAG Executive Committee.

The 1987 Georgia General Assembly took a significant step forward in solving some of the judicial and insurance problems facing physicians. This was accomplished by the Georgia Legislature passing two major bills dealing with the general subject of "Tort Reform."

Based more on political posturing than legal necessity, the "Medical Malpractice Reform Act of 1987" was enacted through Senate Bill 2; and the "Tort Reform Act of 1987" was found in House Bill 1. The two combined bills consisted of eight of the ten major reforms sought by the Medical Association of Georgia. The eight reforms included:

1. reduced statute of limitations for minors;

2. pre-filing affidavits;
3. limited immunity for some free medical care;
4. \$250,000 cap and modification of punitive damages awards;
5. disclosure to the jury of "collateral sources" of compensation;
6. judicial modification of jury verdicts;
7. modification of the "joint and several" liability rule;
8. immunity for directors, trustees, members, and uncompensated officers of some non-profit governmental organizations.

The eight major reforms found in the Medical Malpractice Reform Act of 1987 and the Tort Reform Act of 1987 are not perfect, but they do constitute a substantial step in the right direction. It is anticipated that each of these eight sections will be litigated for many years to come. They will not lead to an immediate lowering of insurance premiums, but hopefully they will help stabilize the trend to even higher rates. They are a beginning, not an end. There is preliminary data indicating that the enacted reforms are having a beneficial affect. Also, our public education efforts appear to be paying off by a greater awareness of who pays for a large verdict. The physicians of Georgia should be proud of their legislative accomplishments and of the leadership they exhibited on this issue.

Although we did not officially meet during the 1987-88 year, our Committee worked enthusiastically with the Georgia Liability Crisis Coalition finding alternatives and solutions to the Liability Crisis. The Coalition also published a newsletter during this past legislature outlining all tort-related legislation. The 1988 legislative session saw the introduction of several bills by trial lawyers to repeal or weaken our 1987 legislative gains. None of these proposals met with success.

We will continue to monitor any future legislation that may be introduced on this subject matter and

will continue to work with MAG Mutual and any other interest group in dealing with any issues of Tort Reform that may develop in the future.

### Recommendations

1. That the Ad Hoc Committee for Tort Reform be continued.

2. That this Committee continue its monitoring of legislative activities as they relate to Tort Reform.

3. That the Committee continue its study of legislative initiatives for future introduction and action by the General Assembly.

4. That the concept of alternatives to the judicial process (i.e. arbitration, catastrophic injury funds like Virginia, etc.) be studied by the Committee.

5. That MAG continue its activities with the Georgia Liability Crisis Coalition.

### House Action

Recommendation 1 of this report was combined with the Recommendation of the Ad Hoc Committee to Study Alternatives to Tort Reform and both were adopted as amended: "That the studies of the Ad Hoc Committee to Study Alternatives to Tort Reform be continued by the Ad Hoc Committee for Tort Reform and that the Ad Hoc Committee for Tort Reform incorporate the goals of the Ad Hoc Committee to Study Alternatives to Tort Reform."

Adopted Recommendation 2.

Recommendation 3 was considered along with Recommendation 7 of the President's Report and Recommendation 1 of the First Vice President's Report and were adopted by deletion and substitution: "That this Committee, working through the Legislative Council at the direction of the Executive Committee, strive for introduction and action on tort reform initiatives by the General Assembly during the 1989-90 term."

Adopted Recommendation 4 as amended: "That the concept of alternatives to the judicial process



(i.e., arbitration, catastrophic injury funds like those adopted by Virginia, etc.) be studied by the Committee and reported regularly to the Executive Committee and Board of Directors.

Adopted Recommendation 5.

## RESOLUTION 5

### **Diversion of Legitimate Schedule II Narcotic Drugs/Multi-copy Prescription Bill**

**Medical Association of Atlanta**

*Whereas*, the House of Delegates in response to a resolution adopted in 1985 did form an *ad hoc* committee to work with various public industry and concerned organizations to draft model legislation to solve the problem of diversion of legitimate prescription drugs; and,

*Whereas*, the Committee recommended passage of a multi-copy prescription bill in the Georgia General Assembly to solve this problem; and,

*Whereas*, the House of Delegates in 1986 adopted a resolution calling for MAG to work with the GBI and other interested groups to submit and work toward passage of a mutually acceptable bill; and,

*Whereas*, in 1987 the *ad hoc* committee was re-established by the President of MAG at the request of the Attorney General of Georgia; and,

*Whereas*, there is generalized public support for passage of a multi-copy prescription bill; and,

*Whereas*, there is uniform agreement among concerned law enforcement agencies; and,

*Whereas*, there is uniform agreement among criminal justice oversight organizations; and,

*Whereas*, there is agreement in the Governor's Commission on Drug Abuse Awareness and Prevention; and,

*Whereas*, there is ample expertise resident within the House of Delegates to adequately explain and design such legislation; now, therefore, be it

**RESOLVED**, that the House of Delegates endorse the passage of a multi-copy prescription bill as was recommended by the MAG *Ad Hoc* Committee on Diversion of Legitimate Prescription Drugs.

#### **House Action**

Adopted the substitute Report of the Ad Hoc Committee on Diversion of Legitimate Prescription Drugs in lieu of Resolution 5.

## RESOLUTION 16

### **Military Interception of Illegal Drugs**

**Ogeechee River Medical Society**

*Whereas*, the United States of America is in a defacto war over the introduction of illegal drugs into this Country; and,

*Whereas*, the introduction of illegal drugs into this Country is not only the source of a major health problem, but also represents a major threat to the national security of our Country; now, therefore, be it

**RESOLVED**, that the MAG urge the AMA to use all its influence to compel the U.S. Government to utilize our military force to its fullest to intercept and interrupt this flow of illegal drugs into this Country.

#### **House Action**

Adopted as amended: "That the MAG urge the AMA House to use all its influence to compel the U.S. Government to utilize all appropri-

ate resources at its disposal to intercept and interrupt the flow of illegal drugs into this country."

## RESOLUTION 18

### **Medicare Reimbursement Caps DeKalb Medical Society, Inc.**

*Whereas*, providers who do not accept Medicare assignment have never signed a contract with the Federal Government; and,

*Whereas*, it is unprecedented for a cap to be placed on the charges of a professional group when such reimbursement limits are not being developed for other professional people and businesses; and,

*Whereas*, it is our opinion that such caps are unconstitutional; now, therefore, be it

**RESOLVED**, that MAG, through its delegation to the American Medical Association and Georgia Congressmen, work diligently and aggressively to abolish these highly unfair and unconstitutional reimbursement caps.

#### **House Action**

Adopted as amended: "That MAG, through its delegation to the American Medical Association and with the Georgia Congressional delegation, work diligently and aggressively to abolish these discriminatory reimbursement caps."



### RESOLUTION 20

#### Control of Handguns

Dave M. Davis, M.D.

*Whereas*, handguns are involved in approximately 14,000 suicides in the U.S. each year; and,

*Whereas*, 1800 accidental deaths occur with handguns in the U.S. each year; and

*Whereas*, approximately 9,000 murders occur annually in the U.S. with handguns; and,

*Whereas*, handguns are used to wound, rape, rob and threaten hundreds of thousands more; and,

*Whereas*, foreign experience demonstrates that handgun control laws work; now, therefore, be it

**RESOLVED**, that the Medical Association of Georgia support a statewide waiting period and background check to screen out illegal handgun purchasers such as convicted felons and drug users; and be it further

**RESOLVED**, that the Medical Association of Georgia support statewide mandatory jail sentences for using handguns in the commission of crimes; and be it further

**RESOLVED**, that the Medical Association of Georgia support a license-to-carry law, requiring a special state license to carry a handgun outside one's home or place of business; and be it further

**RESOLVED**, that the Medical Association of Georgia support a statewide ban on the manufacture and sale of snub-nosed handguns (Saturday night specials); and be it further

**RESOLVED**, that the Medical Association of Georgia support a ban on the manufacture and sale of plastic handguns which make metal detectors and airport screening devices useless; and be it further

**RESOLVED**, that this Resolution be published to both the Georgia media and Georgia legislators.

#### House Action

Filed. Floor amendment to adopt Resolve 5 passed.

### RESOLUTION 22

#### MAG Legislation

#### South Georgia Medical Society

*Whereas*, bills introduced to the Georgia General Assembly frequently affect certain medical specialty groups more directly than others; and,

*Whereas*, the Medical Association of Georgia, in developing its position on said legislation is called upon to reflect the interests of the respective specialty groups; now, therefore, be it

**RESOLVED**, that in cases where a medical specialty is directly or indirectly affected by a bill submitted to the Georgia General Assembly, that the MAG Legislative Committee and staff should make every effort to obtain representative opinions and counsel from that specialty society before making a decision whether to oppose or favor the legislation in question.

#### House Action

This Resolution was considered along with Recommendation 6 of the Legislative Council and were both adopted by deletion and substitution: "That specialty groups be encouraged to consult with the Legislative Council prior to hiring independent lobbyists or consultants, and such lobbyists or consultants be encouraged to work with MAG legislative staff for better coordination of efforts."

### RESOLUTION 23

#### Funding for Grady Memorial Hospital

Martin Moran, M.D.

*Whereas*, Grady Memorial Hospital, supported by the Fulton-DeKalb Hospital Authority, provides medical care for indigent patients residing throughout the metropolitan Atlanta area, including counties other than Fulton and DeKalb; and,

*Whereas*, taxpayers in Fulton and DeKalb counties are thus paying for indigent care rendered to non-Fulton/DeKalb residents; and,

*Whereas*, state appropriations to Grady Memorial Hospital are presently limited to special grants for specific diseases such as AIDS, poison control, and sickle cell, without addressing the funding given at Grady to the population of north-west northcentral Georgia; now, therefore, be it

**RESOLVED**, that the Medical Association of Georgia support legislative action in the next General Assembly to provide increased state appropriations to Grady Memorial Hospital's program of medical care for the indigent.

#### House Action

This Resolution was considered with Recommendation 2 of the Ad Hoc Committee on Medical Care for the Disadvantaged; together they were adopted by deletion and substitution: "That MAG continue to press for Georgia legislative and gubernatorial action concerning health care for the disadvantaged, and encourage increased state funding for hospitals with significant populations of indigent patients."



## RESOLUTION 25

### Insurance for Well Child Supervision

Georgia Medical Society

*Whereas*, our children represent one of, if not the most important asset that our society has; and

*Whereas*, we have shown that routine well child supervision, such as has been provided by EPSDT Screening and immunization programs, will provide more optimum care and decrease the overall costs of child health care; and,

*Whereas*, many of the parents of our children are at the low end of the scale financially and out of pocket medical expenses, if not for an emergency, are out of the question; and,

*Whereas*, for a substantial number of our children, for a relatively small cost through present insurance programs, we can provide well child supervision and immunization through their own private physicians which will enhance their health; now, therefore, be it

**RESOLVED**, that the Medical Association of Georgia support the concept of mandated insurance coverage for well child supervision, which should include cognitive care and immunizations, for those policies involving family plans which cover children.

#### House Action

Adopted as amended: "That MAG strongly support the concept of insurance coverage for well child supervision and that MAG work aggressively with physicians and insurance carriers toward this goal. Progress on this issue is to be reported at each Board of Directors meeting."

## RESOLUTION 28

### Preservation of Animal Resources for Biomedical Research

Garland Perdue, M.D.

*Whereas*, access to animals for crucial biomedical research is in danger of being severely limited or restricted due to lobbying efforts by animal rights activists; and,

*Whereas*, some animal rights activists use emotionalism, half-truths and lies to discredit animal research; and,

*Whereas*, there is an urgent need to educate the public, media, government officials and legislators as to the seriousness of the problem and the likelihood that it will grow in intensity as well-financed animal rights activists continue to agitate for ever-increasing restrictions in animal research; and

*Whereas*, the most immediate danger of inaccessibility to animals exists at the state and local levels; and,

*Whereas*, progress has been made in defending the need to use animals in research by both the National Association for Biomedical Research (NABR) and the newly formed Georgia Association for Biomedical Research; and,

*Whereas*, MAG is represented on the Board of the Georgia Association for Biomedical Research; and,

*Whereas*, taking an active role in defending biomedical research is a reaffirmation of the historical role of organized medicine; now, therefore, be it

**RESOLVED**, that the Medical Association of Georgia, actively defend the use of, and access to animals for use in crucial biomedical research; and be it further

**RESOLVED**, that MAG support, endorse and participate in the activities of the Georgia Association for Biomedical Research.

#### House Action

Adopted the first RESOLVED portion as amended: "That the Medical Association of Georgia actively defend the use of, and access to animals for use in biomedical research according to applicable guidelines; and be it further."

Adopted the second RESOLVED portion as amended: "That MAG support, endorse and participate in the activities of the Georgia Association for Biomedical Research as long as its activities remain consistent with MAG's goals."

## RESOLUTION 33

### Medico-Legal Death Investigation in Georgia

Medical Association of Atlanta

*Whereas*, historically, laws pertaining to official medico-legal death investigation in Georgia have been written and made law by the General Assembly with little or no input from the medical community; and,

*Whereas*, historically, laws pertaining to death investigation were largely conceived and supported by individuals who were not or are not medical doctors or doctors of osteopathy; and,

*Whereas*, historically and presently, laws pertaining to death investigation in Georgia permit the performance of autopsies and rendering of medical opinion by individuals who are not medical doctors or doctors of osteopathy; and,

*Whereas*, investigation of death often involves the performance of autopsies and the rendering of medical opinion and diagnoses and therefore involves the practice of medicine; now, therefore be it



RESOLVED, that the Medical Association recognize the potential for, and present practice of investigation of death and its medical issues in Georgia by persons with inappropriate or insufficient education and training to do so from the medical standpoint; and be it further

RESOLVED, that the Medical Association of Georgia support a general policy and changes in applicable laws which would require that the performance of autopsies and the official investigation of the medical aspects of death be conducted by licensed physicians only.

### House Action

Adopted first "RESOLVED."

Adopted as amended the second RESOLVE: "That the Medical Association of Georgia support a general policy and changes in applicable laws which would require that the performance of autopsies and the official investigation of the medical aspects of death be conducted by qualified licensed medical doctors and osteopaths."

## RESOLUTION 34

### Investigation of Medical Aspects of Death

#### Medical Association of Atlanta

*Whereas*, the death investigation system in Georgia is presently and largely organized and administered by the Georgia Bureau of Investigation's division of Forensic Sciences, which are law enforcement agencies; and,

*Whereas*, the function of a medical examiner is not one of law enforcement, but rather, the medically oriented, non-biased investigation of death to formulate a

medical opinion of the cause and manner of death; and,

*Whereas*, the majority of deaths investigated by the medical examiner do not involve crimes and are therefore unrelated to law enforcement, and deaths involving crime should include medical investigation which is non-prosecutorial in nature; and,

*Whereas*, the present structure of the death investigation system in Georgia allows for a law enforcement agency to investigate itself; and,

*Whereas*, many other states have recognized the importance of separating the medical investigation of death from law enforcement and no other states permit the performance of medico-legal autopsies by non-physicians; now, therefore, be it

RESOLVED, that the Medical Association of Georgia encourage and support the establishment of a State Agency, independent of law enforcement, charged with the responsibility of administering the investigation of the medical aspects of deaths which presently qualify for investigation under the Georgia Postmortem Act; and be it further

RESOLVED, that the Medical Association of Georgia support the position that such a State Agency be administered and operated by licensed medical doctors with training and experience in medico-legal death investigation.

### House Action

Did not adopt at the request of the author.

## RESOLUTION 37

### Peer Review Contract With Board of Medical Examiners

#### Dolford F. Payne, Jr., M.D.

*Whereas*, in a membership opinion survey conducted by the Medical Association of Atlanta (MAA) in October 1987, 84% of respondents indicated that the highest priority of MAA in the future should be to "maintain high professional standards and diligently investigate and report unethical practices of members"; and,

*Whereas*, the MAA in February 1988 adopted a three-year Strategic Plan in which the first goal is "to promote ethical conduct by physicians and develop mechanisms to endorse such conduct"; and,

*Whereas*, one of the objectives to achieving the above goal is to "seek full protection under state statutes for the MAA to conduct peer review activities and submit information to appropriate regulatory bodies"; and,

*Whereas*, under current state statutes there is immunity from criminal and civil liability for professional health care providers who conduct peer review activities so long as such providers act without malice or fraud, however, such immunity does not apply to any action in tort or contract brought against a peer review committee; and,

*Whereas*, such peer review committees would be provided greater protection against tort and contract claims if acting under the auspices and as a regulatory arm of the State Board of Medical Examiners; and,

*Whereas*, funding is inadequate to support the State Board of Medical Examiners in investigating the myriad of complaints against physicians for unethical or illegal practices; and,



Whereas, being fully cognizant that the future of peer review may very well hinge on the case of *Patrick v. Burget et al* currently before the U.S. Supreme Court; now, therefore, be it

**RESOLVED**, that the Medical Association of Georgia (MAG) pursue the adoption of legislation and to amend the Rules and Regulations of the Composite State Board of Medical Examiners to permit the Board to employ the peer review services of the MAG and any of its component societies by contract as a regulatory function of and under the statutory protection and immunity of the State.

### House Action

Referred to the Board of Directors for study.

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# Report Reference Committee



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## PRESIDENT'S REPORT

**Jack F. Menendez, M.D.,  
President**

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**D**uring its meeting of April 29, Reference Committee D gave careful consideration to its referred reports and resolutions. The following physicians were members of that Committee:

A. Bleakley Chandler, M.D.; Robert D. Gongaware, M.D.; John A. Hudson, M.D.; Alan C. Plummer, M.D.; John E. Roberts, Jr., M.D.; Michael H. Roberts, M.D.; and William A. Wolff, M.D.

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*Referred to: Rec. 1, 2 (a, b), 3, 4, 5 — Reference Committee D; Rec. 2 (c, d) — Reference Committee C; Rec. 6 — Reference Committee A; Rec. 7 — Reference Committee C.*

(See Report of Reference Committee A for complete President's Report.)

### Recommendations

1. That the MAG House of Delegates meet twice a year.
2. That, at the President's discretion:
  - a. The Second Vice-President chair the Membership Committee;
  - b. The First Vice-President supervise all Ad Hoc Committees;
3. That the Chairman of the AMA delegation sit on the Executive Committee.
4. That the Executive Committee meet every six weeks, or by the call

of the President, but not prior to meetings of the House of Delegates.

5. That the Board of Directors meet twice a year, between meetings of the House of delegates.

### House Action

Recommendations 1, 2a, 2b, 3, and 4 were referred to the Board of Directors. Recommendation 5 was not adopted.

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## FIRST VICE PRESIDENT

**Joe L. Nettles, M.D.**

*Referred to: Rec. 1 — Reference Committee C; Rec. 2 — Reference Committee D; Rec. 3 — Reference Committee A.*

### Recommendation

2. A statewide or nationwide surcharge, or added tax on all or high-risk surgical procedures should be implemented to cover mal-occurrences.





*Members of Reference Committee D.*

#### House Action

Referred to MAG Ad Hoc Committee on Tort Reform.

## SECOND VICE PRESIDENT

**Richard W. Cohen, M.D.**

**I**would like to thank the members of the House for electing me to the post of Second Vice President for this past year. It has been a marvelous year, a year of education, a year of involvement, and a year of some action. I have made every effort to be present at all Executive Committee meetings, Board meetings and special called meetings. I have found this year to be enlightening as well as educational.

In assuming this office and pursuing my responsibilities, I have set as my goal the strengthening of the Medical Association of Georgia's posture as an advocate of both physicians and our patients. I believe that in order to do so, the MAG should act as the "umbrella" of all

medical organizations in the state including county medical societies and specialty societies, as well as such groups as young physicians, residents, and medical students. I believe that MAG's position of advocacy for specialty societies is especially important if we are to continue our traditional role of coordinating and influencing medical political activities within this state.

Whereas our House of Delegates is well-structured to represent county medical societies, and whereas it presently has sections for residents, medical students, young physicians and hospital medical staffs, I wish to point out that the House currently has no formal mechanism for recognizing the interests of our state specialty societies. The importance of such formal recognition of specialty interests is of course evident in the AMA's decision to seat delegates and alternates from national specialty societies. Just as the Medical Association of Georgia is the "umbrella" in our state, the American Medical Association realizes its responsibility to serve as an "umbrella" for national specialty soci-

eties, and has accordingly embraced these societies as part of its House of Delegates. Each has been granted a voting delegate and an alternate delegate.

A similar relationship is critical within our state association. If the Medical Association of Georgia is to continue to represent all physicians in our state in the medical political arena, and if we are to have coordinated activities in legislation, professional health care and the assurance of quality medical care, as well as other issues before us, MAG must forge a chain to assure *communication with all our component societies*, whether they be defined by county lines or specialty lines. All of the links within the chain are presently in place with the sole exception of the specialty societies.

It is acknowledged that most of the physicians who presently are delegates to the House are specialists. The fact that they are specialists, however, does not provide specialty representation. The delegates who are currently at the House represent their component medical societies and the views of those medical societies. They act as a





Page Bailey (Mrs. Joseph P., Jr.), member of the Richmond County Auxiliary.

conduit from MAG to the component medical societies and vice versa. However, the fact that they are orthopedists or ophthalmologists or pediatricians in no way provides for communication with their particular specialty society. In fact, in most instances, few, if any, of the delegates to MAG are officers in their respective specialty societies.

Because of all these facts, and in order to ensure the formal MAG-specialty communication which I believe the successful future of organized medicine requires, I would like to recommend that the House of Delegates approve the creation of a specialty section of the House, with the major state societies each represented by a single voting delegate and a single alternate delegate. It would be hoped that the President or Vice President of the given specialty society would be the delegate of the society in the House and would thereby provide increased communication and input

from the individual society to MAG and from the MAG to the individual society.

Finally, I would like to address a philosophy or credo for the future of the medical profession. I believe that over the last twenty years the medical profession has held a defensive and reactive posture. To correct this, there is a need for physicians in general and our organization in particular to redirect its posture and philosophy to a proactive and offensive philosophy that supports and promotes physicians, medicine, quality health care, and that advocates the protection and support of the individual patient. It is critical that each physician become an advocate for all of his or her individual patients, as well as for the patient population of the community at large.

In addition, it is also just as critical that the Medical Association of Georgia stand up and be proud of the quality of medical care which is being provided in the state of Georgia. Our desire and demand for that quality of care should continue to be on its present high level. Moreover, it should continue to grow with future advances in medicine, assuring that at all times there is no weakening in the quality of care being provided within this state.

I would like to thank you for the privilege of having a wonderful year as your Second Vice President, and look forward to the coming year as your First Vice President.

### Recommendation

That the Medical Association of Georgia add to its House of Delegates one delegate and alternate delegate from each major state specialty society.

### House Action

Adopted as amended: "That the Medical Association of Georgia add to its House of Delegates one delegate and alternate delegate, who are MAG members, from each ma-

ior state specialty society now represented on the MAG Specialty Society Relations Committee, and may henceforth be recognized by MAG in accordance with guidelines adopted by the Board of Directors."

## SUPPLEMENTAL REPORT OF SECOND VICE PRESIDENT

Richard W. Cohen, M.D.

**R**eport 5, Second Vice President, is a report that sets forth my views on the need to add a voting delegate and an alternate delegate to the MAG House of Delegates from each of the specialty societies represented on the Association's Committee on Specialty Society Relations.

In order to permit the House of Delegates to debate the merits of such a proposal and subsequently vote for or against it at the 1989 (next year) Annual Meeting, the actual amendment must be introduced at this meeting (1988), printed in the *Journal of the Medical Association of Georgia* during the coming year and then formally presented to the House next year.

Accordingly, the following amendment is placed on the table for a vote at the 1989 House of Delegates meeting:

(Note: Amendments by addition are underlined, and amendments by deletion are ~~crossed-out~~.)

### ARTICLE V — HOUSE OF DELEGATES

SECTION 1. COMPOSITION. The House of Delegates is composed of delegates, elected by the component societies, the specialty societies which are represented on the MAG Committee on Specialty Society Relations, the Resident Physician Section, the Medical Student Section, and Hospital Medical Staff Section. All delegates' qualifica-



tions and terms of office shall be provided for in the Bylaws. The officers, the past presidents of the Association, the Editor of the *Journal*, delegates to the AMA, the Executive Director and chairpersons of standing committees shall be ex-officio members of the House of Delegates without the right to vote.

### House Action

Adopted.

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## HOSPITAL MEDICAL STAFF SECTION

**William B. Jones, M.D.,  
Chairman**

**R**egretfully, during 1986 and 1987 the MAG-HMSS continued to experience a general lack of interest and medical staff involvement in Section activities. Attendance at both the State HMSS meeting in April, 1987, and the AMA-HMSS Assembly meetings in both Chicago and Atlanta was sparse — less than 10 representatives attended the State Association Section Business meeting in 1987 and only three Georgia representatives were registered at the June, 1987 AMA meeting. This pattern of decline has continued over the past several years.

It is interesting that Georgia physician interest has waned at a time when the HMSS National Forum has gained considerable strength and impact within the AMA. Collectively, there are more than 2,200 physicians who have attended AMA-HMSS meetings. Moreover, these 2,200 staff representatives, during the past four years, have spurred the AMA House to act favorably on more than 90 percent of the HMSS-sponsored resolutions. Various reasons have been offered for Georgia's Section's lagging interest — a lack of sufficient responsibility and representation in Association functions, an inadequate budget and

staff resources, a weak organizational link with the AMA-HMSS, and because there are other avenues available and used for medical staff interests.

### Recommendation

1. That the presently constituted MAG Hospital Medical Staff Section be abolished and that either it be possibly reformulated as a committee or that the medical staff interests be assigned to another committee of the Association.

### House Action

Referred to the Board of Directors.

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## ACCESS TO MEDICAL CARE COMMITTEE

**M. Julian Duttera, Jr.,  
M.D., Chairman**

### Medical Fair

The committee continues to work with other agencies in sponsoring the Medical Fair — a program which brings representatives of communities with under 15,000 population who are looking for physicians, and resident physicians looking for places to practice, together. It continues to be successful. The Medical Fair for 1988 will be held at the Waverly Hotel in Atlanta, September 20-24. The State Medical Education Board remains the primary coordinator of this activity. Georgia legislation, currently awaiting the Governor's signature, will establish the State Medical Education Board as a separate entity which, hopefully, will allow it to be more flexible in defining underserved areas in the state.

### Central Physician Placement Service

Although the Joint Board of Family Practice was initiated to develop family practice residencies throughout the state, it has developed an excellent statewide placement service which involves all specialties. It has full-time staff to work with both communities and physicians. It also has access to demographic data about any area of the state. This service is provided free though there may be some fees charged for some demographic reports.

A number of changes in MAG staff and in MAG's computer system has resulted in making the MAG computerized placement system even less effective. For this reason, the Access to Medical Care Committee recommended and the MAG Board of Directors agreed to endorse the Joint Board of Family Practice placement service.

Due to a less than enthusiastic response from the specialty societies, the planned Physician Placement Expo '87 was not conducted.

### Georgia Physician Survey, 1986

In association with the 1986 licensure renewal, the Composite State Board of Medical Examiners conducted a survey of physicians as to their practice sites, specialties, workloads, etc. The response rate varied from 100% for "state of residence" to 73.4% for "hours spent per week in primary specialty." Variables carrying the most weight had a response rate of 97.6% or greater: state of residence, age, county of practice, license number, and specialty. For the first time, this survey provides valid data directly from Georgia physicians relating to their practices. It is our understanding that follow-up data is being collected with the 1988 renewals and that this practice will continue.

A report entitled, "Georgia Physician Survey, 1986," was prepared by the Joint Board of Family Prac-



tice. The report limits its scope primarily to the primary care specialties: family practice, internal medicine, pediatrics, obstetrics & gynecology, and general surgery. This document was prepared in part for presentation to a Legislative Committee to try to help rural areas get physicians. So we believe it will be used as a tool for planning medical services throughout the state. Therefore, the committee feels that the information in this report should be distributed as widely as possible.

As with any survey report, there are ambiguities and concerns about who will interpret the data and how these interpretations may be used.

The report reveals some surprising data, e.g., the national average for physicians per 100,000 population is 192 per 100,000; for Georgia, the average is 148 per 100,000. Even Metro Atlanta is below the national average with 186 physicians per 100,000. Georgia's non-Metro area averages 86 per 100,000, less than half the national average.

There is a great deal of information in the Georgia Physician Survey in 1986 which was prepared by the Joint Board of Family Practice in collaboration with the Composite Board of Medical Examiners. The committee feels that the most striking information, however, is on the current and predicted level of physician supply in the State of Georgia up until the year 2000. The data is based on a survey done of physicians reapplying for licensure in 1986 and is certainly the most reliable data on the physicians in practice in Georgia that has been available up to this point. The information on the physician numbers is compared to an average physician ratio per hundred thousand population of the United States which is about 192 physicians, plus projections based on the GMENAC study done about ten years ago.

Projections were made based on 1985 information from the AMA office in Chicago as to the increase

in physicians over the previous 10 year period of time. The increase during those years ranged from 230 to 441 physicians per year, with an average annual increase of the physician population in Georgia of about 336. To these members, inactive physicians were subtracted to obtain a total physician population. Hospital-based physicians including residents are not easily identified from the AMA data. Because of the difficulty in determining who were residents and who were permanently-based physicians, all physicians were included in calculating the average annual increase. This probably falsely elevates the actual increase in the number of physicians during that time.

Utilizing the information above, it was possible to estimate a growth in the physician supply through the year 2000. From the data base from the Composite Board of Medical Examiners, the number of physicians who will become sixty-five years of age in the year 2000 and before were also calculated, since these people will potentially be retired. About 9% of the practicing physicians in Georgia are currently over the age of sixty-five and continue to practice, but it is probable that this percentage will decrease in years to come because of the increasing difficulty in paying for malpractice insurance when one is not practicing full time.

If the physician population continues to grow, not at an average annual rate of 336, as determined from the AMA data, but at an increased rate as evidenced in the 1978-85 period, then it is estimated that some 400 physicians will be added each year to the Georgia Physician population. Then by 1990, we will add 1,600 new physicians, although due to retirement we would lose 1,025 with a net gain of 575 physicians in four years.

In 1990, the physician rate would be projected as 148 (9,550 physicians divided by 6,449,941, the 1990

Georgia projected population). The GMENAC standard for 1990 is 191 per hundred thousand population. Thus, in effect, the ratio remains stable for the next four years. By the year 2000, we would expect to add another 5,600 to the state, based on the assumption of an increase of 400 physicians per year. We would lose 2,651 due to retirement and will have an increase in the total physician supply to 11,924 by the year 2000. Based on the projected additional population in the state at that point, since it is growing rapidly, the rate of physician per hundred thousand will be 160. This is not a substantial increase from the rate of 148 per hundred thousand in 1990.

The impact of this information is important to all physicians practicing in this state. As is apparent in Table III, the physician population even in Atlanta is *less* than the national average. Within the rural areas of the state, the physician population is less than *one-half* of the national average. Without an influx of physicians from outside the state, or a change in the pattern of training physicians in Georgia, there will still be a considerable deficit within physicians caring for people within the State of Georgia. This will be significantly impacted by the estimated population growth where we expect the growth from about 6,500,000 in 1990 and 7,500,000 by the year 2000. The needs of the various specialties and other areas of special need are highlighted by the report. It is extremely important for physicians to be aware of this data and to have these concepts in mind in projecting their physician recruitment and in thinking about the future.

### Recommendation

1. That the MAG advise its members about the availability of the physician survey report.





(ciprofloxacin HCl/Miles)



## A REVOLUTIONARY ORAL ANTIMICROBIAL WITH THE POWER OF PARENTERALS

- Highly active *in vitro* against a broad range of gram-positive and gram-negative pathogens, including methicillin-resistant *Staphylococcus aureus* and *Pseudomonas aeruginosa*\*
- For treatment of infections in the:
  - lower respiratory tract<sup>†</sup>
  - urinary tract<sup>†</sup>
  - skin/skin structure<sup>†</sup>
  - bones and joints<sup>†</sup>
- Convenient *B.I.D.* dosage – 250 mg, 500 mg and 750 mg tablets

\**In vitro* activity does not necessarily imply a correlation with *in vivo* results.

<sup>†</sup>Due to susceptible strains of indicated pathogens. See indicated organisms in Brief Summary.

CIPRO® SHOULD NOT BE USED IN CHILDREN OR PREGNANT WOMEN.

A history of hypersensitivity to ciprofloxacin is a contraindication to its use. A history of hypersensitivity to other quinolones may also contraindicate the use of ciprofloxacin.



Miles Inc.  
Pharmaceutical Division  
400 Morgan Lane  
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Please see adjacent page of this advertisement for Brief Summary of Prescribing Information.



# Cipro<sup>®</sup> TABLETS (ciprofloxacin HCl/Miles)

■ 500 mg B.I.D. for most infections;  
750 mg B.I.D. for severe or complicated infections.

## BRIEF SUMMARY CONSULT PACKAGE INSERT FOR FULL PRESCRIBING INFORMATION INDICATIONS AND USAGE

Cipro<sup>®</sup> is indicated for the treatment of infections caused by susceptible strains of the designated microorganisms in the conditions listed below:

**Lower Respiratory Infections** caused by *Escherichia coli*, *Klebsiella pneumoniae*, *Enterobacter cloacae*, *Proteus mirabilis*, *Pseudomonas aeruginosa*, *Haemophilus influenzae*, *Haemophilus parainfluenzae*, and *Streptococcus pneumoniae*.

**Skin and Skin Structure Infections** caused by *Escherichia coli*, *Klebsiella pneumoniae*, *Enterobacter cloacae*, *Proteus mirabilis*, *Proteus vulgaris*, *Providencia stuartii*, *Morganella morganii*, *Citrobacter freundii*, *Pseudomonas aeruginosa*, *Staphylococcus aureus* (penicillinase and nonpenicillinase-producing strains), *Staphylococcus epidermidis*, and *Streptococcus pyogenes*.

**Bone and Joint Infections** caused by *Enterobacter cloacae*, *Serratia marcescens*, and *Pseudomonas aeruginosa*.

**Urinary Tract Infections** caused by *Escherichia coli*, *Klebsiella pneumoniae*, *Enterobacter cloacae*, *Serratia marcescens*, *Proteus mirabilis*, *Providencia rettgeri*, *Morganella morganii*, *Citrobacter diversus*, *Citrobacter freundii*, *Pseudomonas aeruginosa*, *Staphylococcus epidermidis*, and *Streptococcus faecalis*.

**Infectious Diarrhea** caused by *Escherichia coli* (enterotoxigenic strains), *Campylobacter jejuni*, *Shigella flexneri*, and *Shigella sonnei*\* when antibacterial therapy is indicated.

\*Efficacy for this organism in this organ system was studied in fewer than 10 infections.

Appropriate culture and susceptibility tests should be performed before treatment in order to isolate and identify organisms causing infection and to determine their susceptibility to ciprofloxacin. Therapy with Cipro<sup>®</sup> may be initiated before results of these tests are known; once results become available appropriate therapy should be continued. As with other drugs, some strains of *Pseudomonas aeruginosa* may develop resistance fairly rapidly during treatment with ciprofloxacin. Culture and susceptibility testing performed periodically during therapy will provide information not only on the therapeutic effect of the antimicrobial agent but also on the possible emergence of bacterial resistance.

### CONTRAINDICATIONS

A history of hypersensitivity to ciprofloxacin is a contraindication to its use. A history of hypersensitivity to other quinolones may also contraindicate the use of ciprofloxacin.

### WARNINGS

CIPROFLOXACIN SHOULD NOT BE USED IN CHILDREN OR PREGNANT WOMEN. The oral administration of ciprofloxacin caused lameness in immature dogs. Histopathological examination of the weight-bearing joints of these dogs revealed permanent lesions of the cartilage. Related drugs such as nalidixic acid, cinoxacin, and norfloxacin also produced erosions of cartilage of weight-bearing joints and other signs of arthropathy in immature animals of various species (SEE ANIMAL PHARMACOLOGY SECTION IN FULL PRESCRIBING INFORMATION).

### PRECAUTIONS

**General:** As with other quinolones, ciprofloxacin may cause central nervous system (CNS) stimulation, which may lead to tremor, restlessness, lightheadedness, confusion, and very rarely to hallucinations or convulsive seizures. Therefore, ciprofloxacin should be used with caution in patients with known or suspected CNS disorders, such as severe cerebral arteriosclerosis or epilepsy, or other factors which predispose to seizures (SEE ADVERSE REACTIONS).

Crystals of ciprofloxacin have been observed rarely in the urine of human subjects but more frequently in the urine of laboratory animals. Crystalluria related to ciprofloxacin has been reported only rarely in man, because human urine is usually acidic. Patients receiving ciprofloxacin should be well hydrated, and alkalinity of the urine should be avoided. The recommended daily dose should not be exceeded. Alteration of the dosage regimen is necessary for patients with impairment of renal function (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION).

#### Drug Interactions:

Concurrent administration of ciprofloxacin with theophylline may lead to elevated plasma concentrations of theophylline and prolongation of its elimination half-life. This may result in increased risk of theophylline-related adverse reactions. If concomitant use cannot be avoided, plasma levels of theophylline should be monitored and dosage adjustments made as appropriate.

Antacids containing magnesium hydroxide or aluminum hydroxide may interfere with the absorption of ciprofloxacin, resulting in serum and urine levels lower than desired; concurrent administration of these agents with ciprofloxacin should be avoided.

Probenecid interferes with the renal tubular secretion of ciprofloxacin and produces an increase in the level of ciprofloxacin in the serum. This should be considered if patients are receiving both drugs concomitantly.

As with other broad-spectrum antibiotics, prolonged use of ciprofloxacin may result in overgrowth of nonsusceptible organisms. Repeated evaluation of the patient's condition and microbial susceptibility testing is essential. If superinfection occurs during therapy, appropriate measures should be taken.

#### Information for Patients:

Patients should be advised that ciprofloxacin may be taken with or without meals. The preferred time of dosing is two hours after a meal. Patients should also be advised to drink fluids liberally and not take antacids containing magnesium or aluminum concomitantly or within two hours after dosing. Ciprofloxacin may cause dizziness or lightheadedness; therefore patients should know how they react to this drug before they operate an automobile or machinery or engage in activities requiring mental alertness or coordination.

#### Carcinogenesis, Mutagenesis, Impairment of Fertility:

Ex *in vitro* mutagenicity tests have been conducted with ciprofloxacin and the test results are listed below:

- Salmonella/Microsome Test (Negative)
- E. coli* DNA Repair Assay (Negative)
- Mouse Lymphoma Cell Forward Mutation Assay (Positive)
- Chinese Hamster V<sub>79</sub> Cell HGPRT Test (Negative)
- Syrian Hamster Embryo Cell Transformation Assay (Negative)
- Saccharomyces cerevisiae* Point Mutation Assay (Negative)
- Saccharomyces cerevisiae* Mitotic Crossover and Gene Conversion Assay (Negative)
- Rat Hepatocyte DNA Repair Assay (Positive)

Thus, two of the eight tests were positive, but the following three *in vivo* test systems gave negative results:

- Rat Hepatocyte DNA Repair Assay
- Micronucleus Test (Mice)
- Dominant Lethal Test (Mice)

Long-term carcinogenicity studies in animals have not yet been completed.

#### Pregnancy—Pregnancy Category C:

Reproduction studies have been performed in rats and mice at doses up to six times the usual daily human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ciprofloxacin. In rabbits, as with most antimicrobial agents, ciprofloxacin (30 and 100 mg/kg orally) produced gastrointestinal disturbances resulting in maternal weight loss and an increased incidence of abortion. No teratogenicity was observed at either dose. After intravenous administration, at doses up to 20 mg/kg, no maternal toxicity was produced, and no embryotoxicity or teratogenicity was observed. There are, however, no adequate and well-controlled studies in

## CONVENIENT B.I.D. DOSAGE

### Recommended dosage schedule

Infection Site*	Severity of Infection	Dosage
Respiratory Tract*	Mild/Moderate	500 mg B.I.D.
Bone and Joint*	Severe/Complicated	750 mg B.I.D.
Skin/Skin Structure*	Severe/Complicated	750 mg B.I.D.
Urinary Tract*	Mild/Moderate	250 mg B.I.D.
	Severe/Complicated	500 mg B.I.D.
Infectious Diarrhea*	Mild/Moderate/Severe	500 mg B.I.D.

pregnant women. SINCE CIPROFLOXACIN, LIKE OTHER DRUGS IN ITS CLASS, CAUSES ARTHROPATHY IN IMMATURE ANIMALS, IT SHOULD NOT BE USED IN PREGNANT WOMEN (SEE WARNINGS).

#### Nursing Mothers:

It is not known whether ciprofloxacin is excreted in human milk; however, it is known that ciprofloxacin is excreted in the milk of lactating rats and that other drugs of this class are excreted in human milk. Because of this and because of the potential for serious adverse reactions from ciprofloxacin in nursing infants, a decision should be made to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to mother.

#### Pediatric Use:

Ciprofloxacin should not be used in children because it causes arthropathy in immature animals (SEE WARNINGS).

### ADVERSE REACTIONS

Ciprofloxacin is generally well tolerated. During clinical investigation, 2,799 patients received 2,868 courses of the drug. Adverse events that were considered likely to be drug related occurred in 7.3% of courses, possibly related in 9.2%, and remotely related in 3.0%. Ciprofloxacin was discontinued because of an adverse event in 3.5% of courses, primarily involving the gastrointestinal system (1.5%), skin (0.6%), and central nervous system (0.4%).

The most frequently reported events, drug related or not, were nausea (5.2%), diarrhea (2.3%), vomit (2.0%), abdominal pain/discomfort (1.7%), headache (1.2%), restlessness (1.1%), and rash (1.1%).

Additional events that occurred in less than 1% of ciprofloxacin courses are listed below. Those typical quinolones are italicized.

**GASTROINTESTINAL:** (See above), painful oral mucosa, oral candidiasis, dysphagia, intestinal perforation, gastrointestinal bleeding.

**CENTRAL NERVOUS SYSTEM:** (See above), dizziness, lightheadedness, insomnia, nightmares, hallucinations, manic reaction, irritability, tremor, ataxia, convulsive seizures, lethargy, drowsiness, weakness, malaise, anorexia, phobia, depersonalization, depression, paresthesia.

**SKIN/HYPERSENSITIVITY:** (See above), pruritus, urticaria, photosensitivity, flushing, fever, chills, angioedema, edema of the face, neck, lips, conjunctivae or hands, cutaneous candidiasis, hyperpigmentation, erythema nodosum.

**SPECIAL SENSES:** blurred vision, disturbed vision, (change in color perception, overbrightness of light, decreased visual acuity, diplopia, eye pain, tinnitus, bad taste).

**MUSCULOSKELETAL:** joint or back pain, joint stiffness, achiness, neck or chest pain, flare-up of gout.

**RENAL/UROGENITAL:** interstitial nephritis, renal failure, polyuria, urinary retention, urethral bleeding, vaginitis, acidosis.

**CARDIOVASCULAR:** palpitations, atrial flutter, ventricular ectopy, syncope, hypertension, angina pectoris, myocardial infarction, cardiopulmonary arrest, cerebral thrombosis.

**RESPIRATORY:** epistaxis, laryngeal or pulmonary edema, hiccup, hemoptysis, dyspnea, bronchospasm, pulmonary embolism.

Most of these events were described as only mild or moderate in severity, abated soon after the drug was discontinued, and required no treatment.

In several instances, nausea, vomiting, tremor, restlessness, agitation, or palpitations were judged by investigators to be related to elevated plasma levels of theophylline possibly as a result of a drug interaction with ciprofloxacin.

**Adverse Laboratory Changes:** Changes in laboratory parameters listed as adverse events without regard to relationship:

Hepatic—Elevations of: ALT (SGPT) (1.9%), AST (SGOT) (1.7%), alkaline phosphatase (0.8%), LDH (0.4%), serum bilirubin (0.3%).

Hematologic—eosinophilia (0.6%), leukopenia (0.4%), decreased blood platelets (0.1%), elevated blood platelets (0.1%), pancytopenia (0.1%).

Renal—Elevations of: Serum creatinine (1.1%), BUN (0.9%).

CRYSTALLURIA, CYLINDRURIA, AND HEMATURIA HAVE BEEN REPORTED.

Other changes occurring in less than 0.1% of courses were: Elevation of serum gamma-glutamyl transferase, elevation of serum amylase, reduction in blood glucose, elevated uric acid, decrease in hemoglobin, anemia, bleeding diathesis, increase in blood monocytes, and leukocytosis.

### OVERDOSAGE

Information on overdosage in humans is not available. In the event of acute overdosage, the stomach should be emptied by inducing vomiting or by gastric lavage. The patient should be carefully observed and given supportive treatment. Adequate hydration must be maintained. In the event of serious toxic reactions from overdosage, hemodialysis or peritoneal dialysis may aid in the removal of ciprofloxacin from the body, particularly if renal function is compromised.

### DOSAGE AND ADMINISTRATION

The usual adult dosage for patients with urinary tract infections is 250 mg every 12 hours. For patients with complicated infections caused by organisms not highly susceptible, 500 mg may be administered every 12 hours.

Respiratory tract infections, skin and skin structure infections, and bone and joint infections may be treated with 500 mg every 12 hours. For more severe or complicated infections, a dosage of 750 mg may be given every 12 hours.

The recommended dosage for infectious diarrhea is 500 mg every 12 hours.

In patients with renal impairment, some modification of dosage is recommended (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION).

### HOW SUPPLIED

Cipro<sup>®</sup> (ciprofloxacin HCl/Miles) is available as tablets of 250 mg, 500 mg, and 750 mg in bottles of 50, and Unit-Dose packages of 100 (SEE FULL PRESCRIBING INFORMATION FOR COMPLETE INFORMATION).

\* Due to susceptible strains of indicated pathogens. See indicated organisms in Brief Summary.

For further information, contact the Miles Information Service:  
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## COMMITTED TO THERAPEUTIC EFFICIENCY



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### House Action

Adopted as amended: "The MAG shall advise its members about the availability of the Joint Board of Family Practice Report, 'Georgia Physician Survey 1986,' cautioning them that its survey data do not necessarily warrant projections of health manpower in Georgia for the future."

## CONTINUING MEDICAL EDUCATION COMMITTEE

**George A. Shannon, M.D.**

**T**hrough its work this past year, our Committee continues to maintain what we consider to be a record of efficient service in promoting continuing medical education across the state. Our activities have been channeled in several areas.

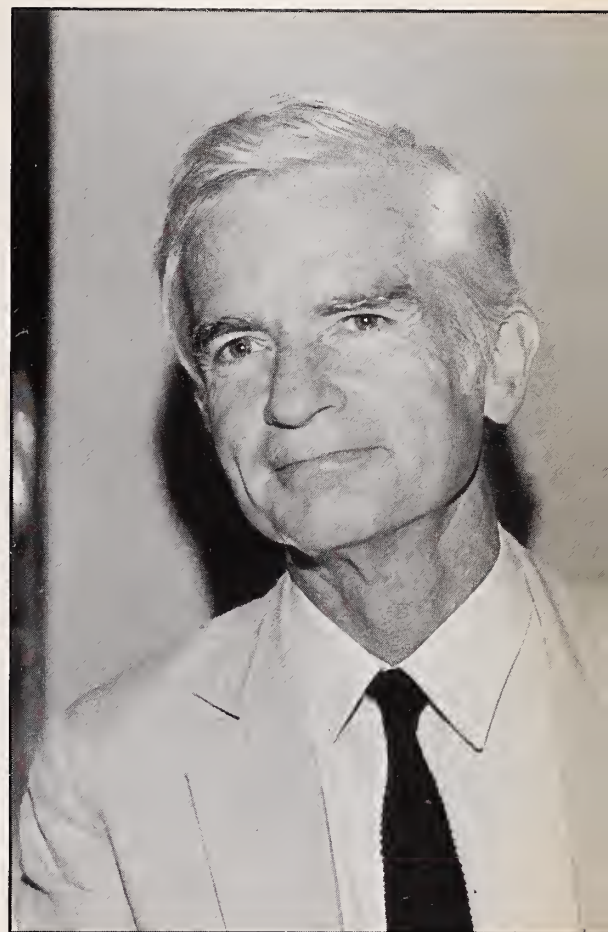
### Accreditation

Our principal ongoing task remains advising and accrediting Georgia organizations and institutions which provide continuing medical education. (Accredited status allows the CME provider to authorize Category 1 AMA credit for appropriate educational activities.) In the past year we've resurveyed nine hospitals and state specialty societies, and extended their period of accreditation according to their ability to meet the ACCME *Essentials* for Category 1 continuing medical education. We've also conducted an initial survey visit of Ridgeview Institute, and evaluated its CME programs for accreditation.

As of this writing, sixteen specialty societies or voluntary health agencies and twenty-two hospitals are accredited for CME by the MAG. These 38 providers are:

American Academy of Pediatrics-Georgia Chapter  
American Cancer Society-Georgia Division  
American Heart Association-Georgia Affiliate  
Athens Regional Medical Center  
Atlanta Society of Pathologists  
Augusta Obstetrical & Gynecological Society  
DeKalb General Hospital  
Georgia Academy of Family Physicians  
Georgia Academy of Family Physicians Educational Foundation  
Georgia Baptist Medical Center  
Georgia Gastroenterologic Society  
Georgia Orthopaedic Society  
Georgia Psychiatric Physicians Association  
Georgia Radiological Society  
Georgia Rheumatism Society  
Georgia Society of Anesthesiologists  
Georgia Society of Ophthalmology  
Georgia Surgical Society  
Glynn-Brunswick Memorial Hospital  
Greater Atlanta Otolaryngology-Head & Neck Surgery Society  
John D. Archbold Memorial Hospital  
Kennesaw Hospital  
The Medical Center  
Medical Center of Central Georgia  
Memorial Medical Center  
Metropolitan Hospital  
Northeast Georgia Medical Center  
Northside Hospital  
Phoebe Putney Memorial Hospital  
Piedmont Hospital  
Scottish Rite Hospital  
South Fulton Hospital  
South Georgia Medical Center  
St. Joseph's Hospital  
Sumter Regional Hospital  
University Hospital  
VA Medical Center (Dublin)  
West Paces Ferry Hospital

During the past year, Committee members and staff have also held consultations with several institutions expressing interest in becoming accredited. We perceive that some of this interest reflects recent



*Dr. Joe Nettles, of Savannah, former Chairman of the MAG Board of Directors.*

state legislative activity regarding an annual minimum of CME, mandated by the state for relicensure.

### Mandatory CME

Last year, the MAG House of Delegates discussed our Association's position regarding mandatory continuing medical education, and reaffirmed its support for voluntary CME, which the MAG articulated in a formal position statement in 1979. In view of the anticipated discussions on CME in the Georgia General Assembly, the House directed that we review this MAG "Statement on Continuing Medical Education" and adapt it to the prospective legislative situation. This Committee has fulfilled the House's charge, and



on May 17, 1987, the MAG Executive Committee approved a slightly modified MAG "Statement on CME." Its main provision states:

The primary purpose of relicensure should be to assure that the physician is competent to continue rendering quality care, and since there has not yet been convincing proof linking CME to physician competence, it would be premature to mandate CME for relicensure. States with such requirements have encountered considerable problems with enforcement and administration.

As we expected, there was introduced during the 1988 General Assembly a bill mandating CME for Georgia physicians. State Senator Bev Engram (D-Fairburn) introduced S.B. 444, which called upon the Composite State Board of Medical Examiners to set a minimum number of hours of approved continuing medical education activities which would be required for relicensure. The bill languished in the Senate Human Resources Committee during much of the session, and died there.

I should add that in mid-February I went to Atlanta and met with Senator Engram to apprise her of MAG's viewpoints on continuing medical education. Our discussions were beneficial and amicable, but they did not seem to sway Ms. Engram from her position.

We may expect that next year a mandatory CME bill will once again be introduced to the General Assembly. When this happens, MAG will face even more difficulty in convincing legislators that our present system of purely voluntary CME ought to be retained. Because of the likelihood that some form of mandatory CME will be reintroduced into the Georgia General Assembly sometime in the future, we have added our first recommendation.

### Composite State Board Questionnaire

You may recall that last year the MAG House further directed that we should work with the Composite State Board of Medical Examiners "to add questions to the physicians' annual license renewal form in order to ascertain Georgia physicians' participation in continuing medical education."

We did this, and the Composite Board very cooperatively asked physicians, among the 21 items it requested from Georgia physicians last fall, to indicate the number of hours of continuing education earned in the last two years.

The Composite Board is still quantifying data from physicians' responses, but a preliminary report from the Board staff suggests very positive findings: presently, on a purely *voluntary basis*, Georgia's physicians participate in an average of 95 hours of CME within a two-year period. This suggests that Georgia physicians are already engaged substantially in continuing medical education, without any legislative mandate. We believe that if this level of voluntary CME activity continues to be documented to the Composite State Board, there would be much less rationale for a legislative CME mandate. Our second recommendation addresses this point.

### Joint Sponsorship

From time to time our Committee is asked by various unaccredited CME providers to authorize AMA Category 1 credit for their educational meetings. Reflecting the national guidelines for CME, the *Essentials* of the Accreditation Council for Continuing Medical Education, we will authorize no Category 1 credit for a medical meeting unless we have been given the opportunity to participate in program planning. Whenever feasible, we defer an applicant for joint sponsorship to another accredited intrastate provider

— such as the pertinent specialty society or a local hospital.

In the past year, we have reviewed some two dozen requests for cosponsorship, and have agreed to jointly sponsor the following activities:

1. MAG Mutual "Good Practice Policies"/Loss Prevention Seminars, 1987-88

2. Clayton General Hospital "Bioethics Forum," September 22, 1987

3. "Current Trends in Management of Asthmatic Bronchitis," Winder, February 16, 1988

4. "AIDS: Fighting Fear with Facts," Columbus, February 23-25, 1988

5. MAG-DHR videotape, "AIDS Physicians' Education Slide Module"

6. Twelfth Annual Caduceus Club Retreat

7. Seventh District Medical Society meeting, Rome, April 6, 1988.

As chairman, I am indebted to the membership of my Committee — an impressive group of energetic physicians committed to ensuring for the Medical Association of Georgia an influential role in continuing medical education. They are:

John R. Broshears, M.D.; J. Paul Ferguson, M.D.; John A. Hudson, M.D.; James S. Maughon, M.D.; Peter L. Meehan, M.D.; Victor A. Moore, M.D.; Hillary R. Newland, M.D.; Neil G. Perkinson, M.D.; Carl L. Rosengart, M.D.; William E. Silver, M.D.; Barry D. Silverman, M.D.; Rodney L. Smith, M.D.; Roland S. Summers, M.D.; William H. Whaley, M.D.; Charles R. Underwood, M.D.

### Recommendations

1. The MAG should reevaluate its "Statement on Continuing Medical Education" in view of the likely reintroduction of a mandatory continuing medical education bill by the Georgia General Assembly.

2. The MAG should urge the Composite State Board of Medical Examiners to include as part of its



voluntary questionnaire for physician relicensure a question soliciting the number of hours of AMA Category I CME credit earned during the stated reporting period.

### House Action

Adopted both recommendations.

## EMERGENCY MEDICAL SERVICES COMMITTEE

**Rodger Chapman, M.D.,  
Chairman**

During the past year the MAG's Emergency Medical Services Committee considered the topic of Emergency Medical Service and Do Not Resuscitate Orders. Following a growing legislative and judicial trend recognizing that patients, or their surrogates, have the right to refuse medical treatment, guidelines, policies, and in some cases, statutory authority, have been written to address this topic. The MAG Medical Practice Committee, for example, in 1986 and again in 1987 recommended that all hospital medical staffs adopt such Do Not Resuscitate policies. The Joint Commission on Accreditation of Health Care Facilities included it as well in their new Standards for Hospitals as of January 1, 1988. The Georgia Living Will Statute and Georgia Supreme Court Decision of *In re: LHR 1984* have established legal precedents and directives in this area.

Decisions to withhold medical interventions, commonly termed "Do Not Resuscitate" orders, pose special problems for emergency medical services. The committee conducted a special study of these problems in 1987-88 and elected to endorse the six policy statements of the American College of Emergency Physicians on the ethics of

resuscitation. The statements concern ethical principles and do not represent a legal framework of interpretation:

1. All patients should have equal access to resuscitation, and each patient should be assessed individually.

2. In the absence of the patient's personal physician, the emergency physician, while evaluating input from other health care team members, should assume final responsibility for resuscitation decisions.

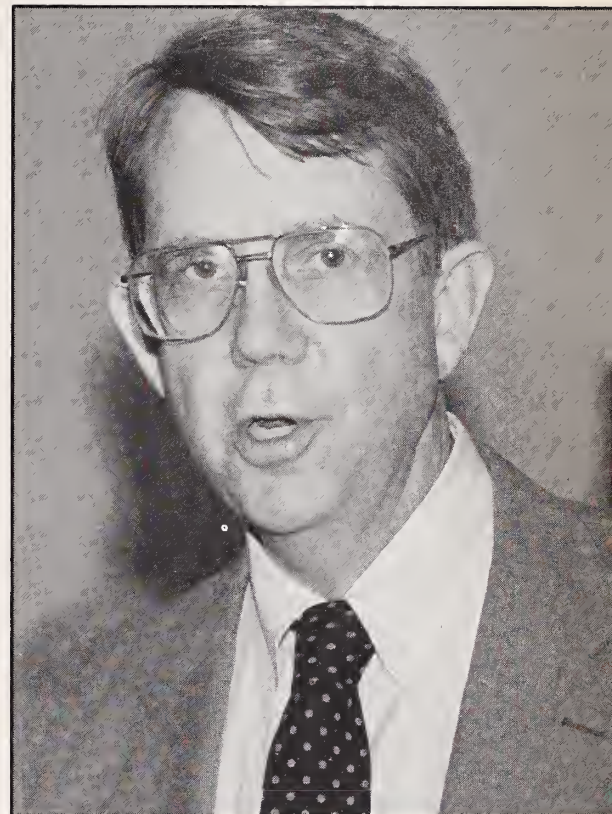
3. Decision to forgo resuscitation in the field is appropriate only with the approval of physician-directed medical control, in keeping with written protocols developed with the concurrence of community agencies and in keeping with community standards.

4. Decisions to forgo resuscitation in the emergency department should be documented, and may be made only if sufficient, reliable data are available with regard to the desired wishes of the patient, the patient's medical status, and possible outcome. In addition, considerations of the ostensible quality of life, the prevailing community standards, directives from the patient's family physician, and family preferences may be taken into account. Lacking sufficient data (a circumstance common in the emergency department setting), resuscitation must be undertaken, with the emergency physician always acting primarily as the patient's advocate.

5. Cost containment concerns may help define the community standards, but should not in and of themselves dictate resuscitate decisions.

6. Resuscitation research may be conducted in emergency medicine, even on an unconscious patient, if expected benefits outweigh the risk to the patient and if appropriate institutional procedures are followed.

Furthermore, the committee recognized that it is important that



*Dr. Joseph Morrison, of Savannah.*

health care institutions and emergency medical services collaborate on written DNR policies in order to anticipate emergencies effectively and to ensure that health care personnel will know how to respond.

Also, during 1987-88, the committee continued their tracking of legislation which impacts significantly on emergency medical services. One new piece of legislation which would have a nationwide effect is Senate Bill 10, the "Emergency Medical Services and Trauma Care Improvement Act of 1987." This legislation would authorize \$75 million in block grants each year for three years to assist states in creating and strengthening trauma care systems. This legislation, presently being considered by the Senate Committee on Labor and Human Resources, could have important implications for an improved trauma network in Georgia.



Finally, the Georgia Department of Human Resources has requested the committee's assistance in organizing a workable state disaster medical system plan. Consultation and advice will be offered during the coming year concerning the role of the medical community in the event of such mass casualty incidents.

### Recommendation

1. The committee recommends that the Association endorse the ethical principles offered by the American College of Emergency Physicians on the ethics of resuscitation and that they communicate them with appropriate medical staffs.

### House Action

Referred to the Board of Directors.

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## MEDICAL SCHOOLS COMMITTEE

**William C. Waters, III,  
M.D.**

**O**ur Committee was established to serve as liaison for MAG with the state's medical schools and to assure communication between academic physicians and private practitioners. Since 1965 the Medical Association of Georgia has facilitated this interaction through its Biennial Conference on Medical Education.

As authorized by the 1987 House of Delegates, our Committee sponsored MAG's twelfth Biennial Conference on Medical Education last October 2-3, in Athens. We had a very good meeting.

Since 1965, this Conference has been held to bring academic and practicing physicians together to discuss subjects of mutual concern. For this past meeting we drew important leaders from all over the

state. Each of the four medical schools sent a delegation, including Dean Tedesco, Dean Skelton and Morehouse's new Dean, Dr. Stanford Roman. Dr. Krause had a conflict, but Emory was represented by three associate deans or faculty. MAG's contingent was headed by Dr. Menendez and Dr. Bailey, and included members of our MAG Medical Schools Committee.

Our agenda was wide-ranging.

(1) Mandatory CME in Georgia. Mr. Fowler and Andy Watry of the Composite State Board discussed prospects for legislative enactment of a mandated minimum level of CME course participation by Georgia physicians. Dr. Menendez explained MAG's position on voluntary CME. Our discussion was aided by Dr. Robert Fore, recently of the Florida Medical Association staff, who explained Florida's problems with a CME requirement. Consensus seemed to be that there was no demonstrable link between physician competence and participation in CME, but that this would probably not deter passage of legislation mandating CME in some form. In that eventuality, nearly all agreed that MAG should help shape the implementing regulations regarding reporting procedures, monitoring of providers, determination of content, etc.

(2) Premedical education. Dr. Hillary Newland of Athens reported his survey of fellow practitioners' views of their baccalaureate education. In short, they wish they had had more liberal arts. Dr. Newland's recommendation that medical deans place more emphasis on liberal arts in their applicants led to a good discussion of the criteria used by the medical schools in selecting their freshmen.

(3) Medical manpower in Georgia. Alan Dever, Ph.D., reported on a survey by the Joint Board of Family Practice of all licensed physicians practicing in Georgia. Details of geographic distribution, demo-

graphic characteristics (age, sex, race) and practice patterns were set forth effectively.

On the basis of this information, Dever hypothesized several projections regarding Georgia's medical manpower in 1990 and 2000. He projected that the number of practitioners in our state would rise from 8975 presently to around 11,924 in the year 2000, but that this increase would still leave our state with a shortage of physicians — a "deficit" of some 2300 (he used GMENAC's ratios to determine adequate physician-population ratios). Our attendees questioned Dr. Dever on a number of his points. We agreed that questions of physician "maldistribution" were being inadequately framed in terms of county-by-county physician population, when medical service areas and patterns of patient transportation frequently do not conform to such boundaries. Our attendees also voiced concern over the GMENAC ratios as the basis of a predicted physician undersupply in our state, and over Dr. Dever's assumption that 400 new physicians would enter practice in Georgia per year.

Because of these concerns, we suggested that the Joint Board of Family Practice use extreme caution in presenting these data and projections to the House Health and Ecology Committee in its meeting last October. Later, unfortunately, both legislators and the press picked up on the Joint Board's emphasis of medically "underserved" areas in Georgia. This attention, we feel, may have contributed to the success of physician assistants during the recent General Assembly in persuading many legislators that PA's should be allowed a more independent scope of practice.

(4) Medical schools' increasing role in the practice of medicine. This was a high point in our weekend, as we reviewed the economic pressures which are leading medical schools increasingly to compete with private practitioners. Dr. Bill



Casarella of Emory reported on the University's expectations that clinical departments will generate most of their operating budget from patient care income. Physicians representing the Medical College of Georgia School of Medicine spoke of declines in grants and state funding, which also were leading to pressures on the clinical faculty to bring private-pay patients into the hospitals.

Other trends discussed included indigent care, new "high tech" modes of patient care, and the development of ambulatory surgery centers. Dr. Roman, speaking for Morehouse, observed that in the face of this latter trend, the maintenance of a patient base in the hospital adequate in size and sufficiently diverse for student teaching posed a particular challenge for a developing school. Dr. Skelton commented that Mercer must compete to keep patients in the hospitals used for teaching.

An observable effect of all this, we felt, was that professors, pressured to generate income, had less time for research. Dr. Mary Ella Logan noted that a bill had been introduced in the Oklahoma legislature a few years ago solely to fund biomedical research in the state's medical schools. Dr. Bailey proposed that the Georgia legislature be encouraged to adopt similar measures.

Because our meeting was so fruitful, we propose that MAG host the Conference on Medical Education annually rather than every two years. We have thus added the recommendations below:

As Chairman, I would like to thank the members of our Committee on Medical Schools for their support and assistance: S. William Clark, III, M.D.; Lois T. Ellison, M.D.; Frank L. Ferrier, M.D.; Harold L. McPheeters, M.D.; James S. Maughon, M.D.; George W. Shannon, M.D.; and H. Kenneth Walker, M.D.

### Recommendations

1. That MAG encourage the Georgia General Assembly to increase state funding of basic research and teaching in all four of Georgia's medical schools.

2. That MAG sponsor this fall, and thereafter annually, its Conference on Medical Education, inviting the four medical school deans and associate deans and such faculty as they deem appropriate to meet with private practicing physicians and MAG officers to discuss issues of mutual concern.

### House Action

First recommendation adopted.

Second recommendation adopted as amended: "MAG sponsor this fall, and thereafter annually, its Conference on Medical Education, inviting the four medical school deans and representative faculty to meet with private practicing physicians and MAG officers to discuss issues of mutual concern."

## AD HOC COMMITTEE ON PHYSICIAN DISPENSING & DRUGS

**Richard A. Wherry, M.D.,  
Chairman**

*Referred to : Rec. 1, 2 —  
Reference Committee D; Rec.  
3, 4 — Reference Committee  
C.*

*(See Report of Reference Committee C for complete report of the Ad Hoc Committee on Physician Dispensing and Drugs.)*

### Recommendations

1. Physicians should maintain the right to dispense medications. Guidelines and recommendations of the American Medical Association's Committee on Ethical and Judicial Affairs must be considered by those physicians who choose to dispense. A physician's decision to dispense medications should be based on potential improvements to patient care, not on financial considerations.

2. MAG should help insure that medical students, residents and practicing physicians continue to be educated in the prescribing and dispensing of medications.

### House Action

Recommendations 1 and 2 adopted.

## RESOLUTION 29

### Specialty Journals

**Charles A. Lanford, M.D.**

*WHEREAS*, the American Medical Association has established a policy which denies family physician members access to specialty journals, except through a subscription basis; and

*WHEREAS*, the American Medical Association distributes specialty journals to non-members in those specialties free of charge; and

*WHEREAS*, the state medical associations across the country are losing family medicine members because of this discriminatory practice; and

*WHEREAS*, the American Medical Association should not offer any services to active members in a discriminatory manner; now, therefore be it

**RESOLVED**, that the Medical Association of Georgia House of Delegates go on record as opposing this discriminatory position; and be it further

**RESOLVED**, that the Medical Association of Georgia House of Delegates direct the Georgia Delegation to the American Medical



Association to introduce a resolution to rectify this inequity.

### House Action

Adopted.

## RESOLUTION 30

### Continuing Medical Education

Wells Riley, M.D.

*WHEREAS*, legislation was introduced into the 1988 Georgia General Assembly providing for mandatory continuing medical education (CME) for physician relicensure; and

*WHEREAS*, because of considerable support for mandatory CME among state legislators, such a bill will again be introduced into the 1988 General Assembly; and

*WHEREAS*, sizable numbers of MAG members believe that a mandatory minimum number of continuing medical education credit hours earned annually for physician relicensure is in the best interests of the medical profession in Georgia; and

*WHEREAS*, increasing numbers of state legislators and growing segments of the general public view physicians' acceptance of mandatory CME as an important aspect of professional integrity, now, therefore, be it

RESOLVED, that the Medical Association of Georgia CME Committee, in cooperation with the state's specialty societies, develop acceptable legislation in support of physicians' participation in continuing medical education as a requirement for medical relicensure in this State.

### House Action

Did not adopt.

## RESOLUTION 32

### Licensure of Foreign Medical Graduates

Phil C. Astin, Jr., M.D.

*WHEREAS*, St. George's University School of Medicine, an "off-shore" medical school, in order to provide appropriate clinical clerkship opportunities for its medical students, has developed relationships with American teaching hospitals, and thus has remediated the chief deficiency generally cited regarding foreign medical schools; and,

*WHEREAS*, many students of St. George's are American students with high academic achievement, possessing very bright prospects as practicing physicians, and who return to this country after graduation to enter approved U.S. residency training programs; and,

*WHEREAS*, in 1985, the Composite State Board of Medical Examiners changed its rules, prohibiting all foreign medical graduates from sitting for the Board Federation Licensing Exam (FLEX) until they have completed three years of internship/residency; and,

*WHEREAS*, formerly, before this rule change, an American citizen foreign medical student (USFMG) could have sat for the FLEX after a single year of internship; and,

*WHEREAS*, denial of the medical doctor's license for these two additional years denies USFMGs who have entered American residency programs the right to "moonlight" during their residency years, thus adding considerable financial burden to them; now, therefore, be it

RESOLVED, that the MAG should petition the Composite State Board to amend its regulations in order to allow U.S. citizen graduates of St. George's who have completed satisfactory clinical clerkships in

American hospitals to sit for the FLEX after a single year of internship.

### House Action

Did not adopt.

## RESOLUTION 36

### Medical School Deans as Delegates

William C. Waters, III, M.D.

*WHEREAS*, the American Medical Association has adopted the position that all state medical societies should be encouraged "to ensure delegate status in the state society's House of Delegates for the deans of medical schools in their state," and,

*WHEREAS*, the Medical Association of Georgia has not accorded delegate status in its House of Delegates to the deans of the four medical schools in our State; and,

*WHEREAS*, each year the Medical Association of Georgia invites the four deans to the MAG House of Delegates meeting, although they are accorded no status other than "guest"; and,

*WHEREAS*, communication and collaboration between the Medical Association of Georgia and Georgia's medical schools will significantly benefit from direct involvement of the deans in the MAG annual House proceedings; now, therefore, be it

RESOLVED, that the Medical Association of Georgia ensure formal status as Delegate in its House of Delegates for the dean of each medical school in Georgia, either through selection at the local society level or through the provision of slotted delegate status.

### House Action

Did not adopt.





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**Slow-K<sup>®</sup>**  
potassium chloride  
slow-release tablets  
8 mEq (600 mg)

It means "dependability" in almost any language

\*Based on worldwide sales data on file, CIBA Pharmaceutical Company.  
Capsule or tablet slow-release potassium chloride preparations should be reserved for patients who cannot tolerate, refuse to take, or have compliance problems with liquid or effervescent potassium preparations because of reports of intestinal and gastric ulceration and bleeding with slow-release KCl preparations.

Before prescribing, please consult Brief Prescribing Information on next page.

C I B A



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**Slow-K®**  
potassium chloride  
slow-release tablets 8 mEq (600 mg)

For patients who can't or won't tolerate liquid KCl.

\*The most common adverse reactions to potassium salts are gastrointestinal side effects.

†Pooled mean serum potassium following oral administration of 30 mEq K-Tab compared to 24 mEq Slow-K in diuretic-treated hypertensives (n = 20) over 8 weeks.

C I B A

**References:** 1. Data on file, CIBA Pharmaceutical Company. 2. Skoutakis VA, Acchiardo SR, Wojciechowski NJ, et al: Liquid and solid potassium chloride: Bioavailability and safety. *Pharmacotherapy* 1980;4(6):392-397. 3. Skoutakis VA, Carter CA, Acchiardo SR: Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics. *Drug Intell Clin Pharm* 1987;21:436-440.

**Slow-K®**  
potassium chloride USP  
Slow-Release Tablets  
8 mEq (600 mg)

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE INSERT)

**INDICATIONS AND USAGE**  
BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.

1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure; hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function; potassium-losing nephropathy; and certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

#### CONTRAINDICATIONS

Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see OVERDOSSAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

#### WARNINGS

**Hyperkalemia** (See OVERDOSSAGE).

In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

#### Interaction With Potassium-Sparing Diuretics

Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

#### Gastrointestinal Lesions

Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

#### Metabolic Acidosis

Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

#### PRECAUTIONS

##### General:

The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

##### Information for Patients

Physicians should consider reminding the patient of the following:

To take each dose without crushing, chewing, or sucking the tablets.

To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.

To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.

To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

##### Laboratory Tests

Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

##### Drug Interactions

Potassium-sparing diuretics: see WARNINGS.

##### Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in animals have not been performed.

##### Pregnancy Category C

Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

##### Nursing Mothers

The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

#### Pediatric Use

Safety and effectiveness in children have not been established.

#### ADVERSE REACTIONS

One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

#### OVERDOSSAGE

The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 mL of 10% dextrose solution containing 10-20 units of insulin per 1,000 mL; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

#### DOSE AND ADMINISTRATION

The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

**Note:** Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

#### HOW SUPPLIED

Tablets—600 mg of potassium chloride (equivalent to 8 mEq) round, buff colored, sugar-coated (imprinted Slow-K)

Bottles of 100 ..... NDC 0083-0165-30

Bottles of 1000 ..... NDC 0083-0165-40

Consumer Pack—One Unit

12 Bottles—100 tablets each ..... NDC 0083-0165-65

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Dispense in tight, light-resistant container (USP).

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# Report

## Reference Committee

# F



*Dr. Cyler Garner, MAG's treasurer, gives his report to Reference Committee F.*

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### TREASURER'S REPORT

**Cyler D. Garner, M.D.,  
Treasurer**

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**R**eference Committee F was comprised of the following physicians: H. Duane Blair, Chairman, DeKalb; Marvyn D. Cohen, Vice Chairman, Muscogee; Bill D. Burk, Floyd-Polk-Chattooga; William R. Hardcastle, DeKalb; Bob G. Lanier, Medical Association of Atlanta; Alva L. Mayes, Bibb; and Dan B. Stevens, Cobb.

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**I**n the Treasurer's Report for the last three years I have emphasized MAG's progress toward achieving organizational goals. In this regard, I believe we cannot overemphasize the importance of a strong financial base upon which to assure your Association's ability to fulfill membership needs.

As I stated last year, "When I took office in 1984, we came within days of having to borrow funds to meet day-to-day expenses. Under these conditions an Association cannot operate in the best interest of its membership. Considering how rapidly our environment changes, MAG must be able to respond quickly to maintain those aspects of medical care to which we are dedicated." These facts are even more true today.

At last year's House of Delegates a budget was passed with a deficit of \$124,676. While an occasional

deficit budget is not always imprudent, we simply cannot afford to allow MAG's financial base to deteriorate. Repeated "deficit budgeting" is not in the best interest of our membership.

A strong representation in organized medicine is important at the state as well as national, county and specialty level. Our membership is paying a substantial amount to support these organizations. We must recognize that there is a limit to what we can expect our membership to pay to support all these associations.

Last year's deficit of \$124,676 would have required a \$25 dues increase to achieve a balanced budget. We have not approved a dues increase for the last two years. Obviously, dues increases are necessary at times; however, we must strive to minimize any such requirements.

The Finance Committee recognizes this dilemma and carefully considered the budget proposal for fiscal year 1989. I might mention that the Finance Committee was expanded to eight members (from 4) following last year's House to facilitate input from the membership.





*Members of Reference Committee F listen as MAG's Director of Administration, Hoyt Torras, answers questions about the Association's annual budget.*

Additionally, this year the Finance Committee met with members of Reference Committee F to provide further input into the budget process.

Considering all the factors presented, the Finance Committee is recommending to the Board of Directors a FY 1989 budget with a small surplus. This budget incorporates a \$25 dues increase (to \$360), the first increase in three years. This represents a 7.5% increase over three years.

I can assure you that this increase is not recommended without a great deal of thought. To meet the proposed budget, we have considered several staff changes and have worked to minimize other administrative expenditures. For example, MAG's budgeted data processing expenditures were \$363,000 in FY 86. For FY 1989 we are budgeting \$175,000 and have reduced data processing staff. We will continue to look for such savings in all areas of the Association's activities to minimize expenditures.

During this next year, we plan to look closely at sources of non-dues income. In this respect, we hope to offer services of real benefit to the

membership which also help to offset dues requirements.

Additionally, to minimize the level of dues increase and improve services, the Finance Committee took two important actions which I wish to present by "laying the cards on the table." These two recommendations will undoubtedly be the most debated portion of the budget proposal.

First, the Finance Committee looked closely at funding requirements for the Impaired Physicians Program. In looking at this Program, the Finance Committee considered the request of the Impaired Physicians Committee for funding of a full-time Medical Director at MAG to coordinate the Impaired Physicians Program. The Finance Committee also heard several innovative ideas to continue and enhance this worthwhile Program.

In short, the Finance Committee believes employment of a medical director will obligate MAG to spend \$200,000 annually by 1990. This would require at least a \$40 dues increase to fund a program which the Finance Committee believes can be coordinated with substantially less funds without directly involv-

ing MAG in the practice of psychiatry and which actually improves access to MAG members.

Basically the FY 1989 proposal by the Impaired Physicians Committee would require \$50,000 to hire a medical director November 1, 1988. This \$50,000 would purportedly cover salaries for the medical director and secretary along with travel and other costs. However, we must recognize that this \$50,000 is for only 7 months and does not include medical liability coverage for the Director and MAG as the sponsoring organization.

In 1990 with a full 12 months of funding necessary, we would be looking at a minimum budget requirement of \$90,000 (excluding liability coverage) and this assumes the director will continue to work for a relatively small salary. Under the Impaired Physician Committee proposal the medical director would receive a salary of \$125,000 in the fiscal year beginning June 1, 1990 and the total budget would approach \$200,000 excluding liability coverage. While the Impaired Physician Committee suggests a surcharge on licensure fees or payments from institutions to fund this



program; to date, there is no assurance such funding will materialize.

I can assure you that the Finance Committee is supportive of the Impaired Physician Program. It has been successful in helping physicians return to active practice. However, we believe this Program can continue under a new plan which better addresses the role of MAG in promoting this worthwhile activity.

I would ask that you consider a plan whereby a network would be established around the state of physicians interested in working with substance abuse problems. A MAG staff member and/or designated physicians would be the contact point for mobilizing help when a physician, his family, peers, or Composite Board recognizes a problem. The 29 members of the Impaired Physicians Committee could promote the program by speaking at county medical society and Auxiliary meetings.

Essentially, this arrangement is similar to that used by some other medical societies. In fact, a recent article in the *California Physician*, the monthly magazine of the California Medical Association, describes their program which is similar to the idea expressed above. The Finance Committee's recommended budget includes \$5,000 to set up a network next year which we believe is an appropriate direction for this program.

The Finance Committee is supportive of programs for impaired physicians, but hopes to avoid a funding crisis "down the road." The Committee believes other alternatives are available which would in fact improve the Program and avoid many of the problems experienced in the past. Finally, the Finance Committee is supportive of the idea of establishing a loan fund to help MAG physicians needing treatment. In fact, such a loan fund would be of direct benefit to MAG members and be relatively easy to establish.

The second key item included in the Finance Committee's recommendations deals with plans to enhance tort reform legislation during the 1989 legislative session. We expect another strong effort to help ameliorate the medical liability crisis. This will require an all out effort by MAG staff in the next twelve months. In addition to public relations, clerical and other staff, we anticipate the equivalent of one full-time legislative staffer devoted to this project.

By the end of this fiscal year, we expect to have accumulated some \$530,072 in the Tort Reform Reserve Account. This is approximately \$50,000 more than the audited balance last year. The Finance Committee recommends that \$75,000 in salaries devoted to Tort Reform be funded from this Reserve Account. Even with this \$75,000 charge the Tort Reform Reserve Account will still amount to \$480,000 by the end of next year when interest earnings are included. Of course, any other required direct expenses would be charged against this account.

The Finance Committee feels this \$480,000 is sufficient to pay for tort reform enhancements and defense of legislation already passed. Because of the structure of our new legislative team, this allocation is appropriate and within the intent of the original dues assessment.

I realize this report has become quite lengthy, but I believe it is easy to forget about our past financial problems. We must be more careful in budgeting to insure funds are spent in the best interest of our membership. Recommendation of tight budgets which minimize requirements for a dues increase always entail tough decisions. The Finance Committee's recommendation accomplishes our objective of improving service to the membership within applicable dues constraints.

In closing, your leadership recognizes MAG's accomplishments

are due to the support of our membership. I wish to express my appreciation for this support. Working together, 6,900 MAG members can accomplish what is best for Georgia's physicians and our patients.

---

## PUBLIC RELATIONS COMMITTEE

**Jeffrey T. Nugent, M.D.,  
Chairman**

*Referred to Rec. 1 — Reference Committee A; Rec. 2 — Reference Committee F.*

**S**ee Report of Reference Committee A for Report of Public Relations Committee.

### Recommendations

The Public Relations Committee requests \$60,000 to carry out its programs for FY1988.

### House Action

Adopted.

### Attachment

Public Relations Expenditures

June 1987-January 1988

See Report of Reference Committee A for this Attachment.



## CHAIRMAN OF THE BOARD OF DIRECTORS

William C. Collins, M.D.

Presented below is the Fiscal Year 1988-1989 MAG Budget as recommended by the Board of Directors:

### BUDGET SUMMARY

<i>Category</i>	<i>Projections May 31, 1988</i>	<i>FY1988 Budget</i>	<i>FY1989 Recommended Budget</i>
<b>Revenue</b>			
Dues Revenue	\$1,705,000	\$1,705,000	\$1,842,000
Risk Management	46,000	10,000	50,000
Advertising Revenue	97,000	120,000	105,600
Scientific Assembly	55,000	40,000	42,500
Leadership Conference	16,300	17,500	15,000
Journal Subscriptions	4,500	5,000	5,000
AMA Refund	8,500	8,500	8,500
Data Processing	55,000	80,000	15,000
Interest Income	89,000	125,000	72,000
Rental Income	26,000	33,000	18,500
Miscellaneous Income	30,000	30,000	46,000
<b>Total Revenue From Regular Operations</b>	<b>\$2,132,300</b>	<b>\$2,174,000</b>	<b>\$2,220,100</b>
<b>Expenditure Summary</b>			
Administration	\$1,118,814	\$1,121,769	\$1,094,387
Membership Services	151,838	163,615	171,925
Building	174,500	182,300	184,000
Journal	185,960	187,009	195,368
Data Processing	188,928	206,347	170,860
Other	3,600	3,600	3,600
Board Contingent	30,000	40,000	20,000
Committees	382,676	394,036	369,473
<b>Total Expenditures Regular Operations</b>	<b>\$2,236,316</b>	<b>\$2,298,676</b>	<b>\$2,209,613</b>
<b>Revenue Over Expense Regular Operations</b>	<b>(\$ 104,016)</b>	<b>(\$ 124,676)</b>	<b>\$ 10,487</b>

<i>Category</i>	<i>Projections May 31, 1988</i>	<i>FY1988 Budget</i>	<i>FY1989 Recommended Budget</i>
<b>Administration</b>			
Salaries	\$ 756,429	\$ 763,060	\$ 695,737
Health Insurance	44,150	43,500	52,500
Disability Insurance	3,900	5,016	4,200
FICA Tax	44,095	39,943	51,250
Unemployment — State	1,450	1,450	1,450
Unemployment — Federal	1,300	1,300	1,300
Retirement	48,150	51,600	53,400
Recruitment	1,200	300	800
Legal Fees	15,000	15,000	15,000
Telephone	48,000	48,500	51,000
Postage	43,400	44,400	49,000



# Reference Committee F

Staff Travel	30,240	30,000	32,000
Printing	2,100	2,500	2,500
Dues & Subscriptions	4,200	2,400	4,500
Audit, Tax & Payroll	29,000	20,000	30,000
Equip. Maintenance & Xerox	18,200	22,300	19,250
Pension Admin.	4,500	4,500	4,500
Temporary Help	2,000	3,500	3,500
Office Supplies	21,500	22,500	22,500
<b>Total — Administration</b>	<b>\$1,118,814</b>	<b>\$1,121,769</b>	<b>\$1,094,387</b>

## Building

Building Maintenance	\$ 9,800	\$ 11,500	\$ 11,000
Janitorial Service	18,000	17,000	18,000
Insurance	12,500	8,800	15,000
Utilities	40,000	43,500	41,000
Depreciation — Building	32,000	33,000	32,000
Depreciation — Equipment	32,000	39,500	32,000
Ad Valorem Tax	30,200	29,000	35,000
<b>Total — Building</b>	<b>\$ 174,500</b>	<b>\$ 182,300</b>	<b>\$ 184,000</b>

<i>Category</i>	<i>Projections May 31, 1988</i>	<i>FY1988 Budget</i>	<i>FY1989 Recommended Budget</i>
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## Membership

Travel — President	\$ 5,000	\$ 7,000	\$ 7,000
Travel — President Elect	4,000	4,000	4,000
Travel — Past President	1,750	3,000	3,000
Travel — AMA Delegates	33,500	35,000	35,000
Caucus Breakfast	2,200	2,600	2,600
Headquarters Suite	10,000	10,000	10,000
Southeastern Coalition	3,700	4,000	4,000
Travel — Sec & Treas to AMA	2,890	3,500	3,500
Two MD's AMA Leadership	1,600	1,600	1,800
AMA — Medical Student Sec	2,740	2,740	10,850
State Med Ed Luncheon	350	375	375
Sundry	550	600	600
Exec Comm Provisional	3,000	6,000	6,000
Exec Comm Travel	7,800	8,700	8,700
Business Coalition	4,000	4,000	4,000
Meetings	10,500	11,000	11,000
Pres Provisional Fund	24,000	24,000	24,000
Pres Exec Fund	16,000	16,000	16,000
Roster	16,258	16,500	16,500
Proceedings	3,000	3,000	3,000
<b>Total Membership</b>	<b>\$ 152,838</b>	<b>\$ 163,615</b>	<b>\$ 171,925</b>

## Journal

Salaries	\$ 46,000	\$ 46,750	\$ 47,650
Health Insurance	4,500	6,026	5,625
FICA	2,620	3,343	5,830
Retirement	2,220	2,940	3,040
Printing	108,000	105,000	108,000
Photo Processing	340	500	500
Advertising Promotion	600	500	500
Postage	13,000	13,000	14,773
Clipping Service	450	450	450
Dues & Subscriptions	250	300	300
Artwork	5,800	6,000	6,500
Travel	2,200	2,200	2,200
<b>Total — Journal</b>	<b>\$ 185,960</b>	<b>\$ 187,009</b>	<b>\$ 195,368</b>



## Other

Franklin Benefits	\$ 3,600	\$ 3,600	\$ 3,600
Board Contingent	30,000	40,000	20,000
<b>Total — Other</b>	<b>\$ 33,600</b>	<b>\$ 43,600</b>	<b>\$ 23,600</b>

<i>Category</i>	<i>Projections May 31, 1988</i>	<i>FY1988 Budget</i>	<i>FY1989 Recommended Budget</i>
<b>Data Processing</b>			
Salaries	\$ 64,000	\$ 71,500	\$ 58,000
FICA	4,588	5,112	4,360
Health Insurance	5,940	5,800	4,000
Disability Insurance	480	590	360
Retirement	3,920	5,720	3,200
Unemployment — State	190	190	190
Unemployment — Federal	170	170	170
Insurance	1,500	1,450	1,500
Equipment Rental	940	2,000	1,500
Equipment Maintenance	31,000	29,000	27,500
Data Communication	720	815	780
Supplies	5,800	7,500	6,000
Depreciation/Amort	58,000	59,000	48,000
Travel	550	2,000	1,500
Education & Dues	130	300	300
Consulting Fees	3,000	5,000	5,000
Office Operations	6,200	7,800	6,500
Documentation	1,800	2,400	2,000
<b>Total — Data Processing</b>	<b>\$ 188,928</b>	<b>\$ 206,347</b>	<b>\$ 170,860</b>

## Committees

Access to Health Care	\$ 2,350	\$ 3,500	\$ 2,000
Annual Session	36,000	36,000	38,000
Auxiliary	63,549	63,549	66,638
Doctor-of-Day	6,300	6,300	7,000
Impaired Physicians	50,000	50,000	5,000
Legislation & Bulletin	62,812	62,812	70,000
PIP	8,915	8,915	10,000
Education	2,300	2,375	2,825
Medical Aspects of Sports	850	1,500	1,200
Physician-Lawyer Liaison	0	5,000	2,000
Membership Insurance	0	1,500	1,500
Public Relations	50,000	50,000	60,000
Scientific Assembly	47,000	40,000	40,000
Newsletter	24,000	19,000	24,900
Third Party Relations	750	2,500	2,500
Leadership Conference	16,300	17,500	15,000
Computers In Medicine	300	1,000	0
Resident Physician Section	5,300	4,130	3,205
Young Physician Section	0	0	3,205
Public Health	1,500	3,000	5,000
Medical Schools	0	1,000	1,000
Membership	500	3,000	3,000
Medical Practice	100	1,500	0
Hospital Medical Staff	2,000	5,000	0
Committee On Disadvantaged	1,000	3,000	3,000
Prof Liability Support	850	1,955	2,500
<b>Total — Committees</b>	<b>\$ 382,676</b>	<b>\$ 394,036</b>	<b>\$ 369,473</b>



## Recommendations

I. It is recommended that funding for the Impaired Physicians Program be set at \$5,000 to establish a network to provide intervention for physicians needing treatment and to promote the program. The Finance Committee feels that approval of a Medical Director will obligate MAG to spend \$200,000 annually by 1990. Please see Treasurer's Report for an expanded discussion of the Finance Committee's proposal as an alternative to employment of a Medical Director.

II. It is recommended that \$75,000 be charged to the Tort Reform Assessment account to offset salaries expended for efforts during FY 1989 to enhance Tort Reform legislation. This is in recognition of the amount of staff time devoted to this important project and the level of Tort Reform Reserve remaining (approximately \$530,000) in relation to anticipated expenditure levels.

III. It is recommended that annual dues be increased by \$25 for full dues paying members to \$360 (other membership categories to be increased proportionately). This increase if approved would be the first in three years, approximately 7.5% over this period.

IV. It is recommended that the Fiscal Year 1989 Budget be submitted to the House of Delegates with a small Excess Revenue Over Expense From Regular Operations of \$10,487.

## House Action

Recommendation 1: Adopted the Minority Report of Reference Committee F as printed below:

## MINORITY REPORT OF REFERENCE COMMITTEE F

**Marvyn D. Cohen, M.D.,  
Muscogee  
William R. Hardcastle,  
M.D., DeKalb**

**M**r. Speaker and Members of the House of Delegates:

The following recommendations are respectfully submitted as a Minority Report to Reference Committee F:

(1) REPORT OF THE CHAIRMAN OF THE BOARD OF DIRECTORS, MAG BUDGET 1988-1989, Rec: 1.

## Recommendation

Mr. Speaker, we advise Recommendation 1 be adopted as amended:

In-house monitoring of records and results of the Impaired Physicians Program is imperative. An M.D. Director (who is currently available) and would be under the supervision of the Executive Director of MAG could direct the Program during the next year and provide:

(a) Information on how the Program functions;

(b) The medical "muscle" to inaugurate alternative methods of funding;

(c) An impartial distribution of cases to treatment facilities;

Funding should be set at an *annualized* amount of \$50,000 and the M.D. Director's services should be limited to Georgia doctors and their families.

Mr. Speaker, this concludes the Minority Report of Reference Committee F.

## House Actions (of Board of Directors Budget, con't)

Recommendation 2: Adopted.  
Recommendation 3: Adopted.

Recommendation 4: Adopted as amended to incorporate substitution of Minority Report to Reference Committee F concerning Impaired Physician Program:

Decrease Salaries, Administration, by \$20,000 to \$675,737;

Decrease Total Administration by \$20,000 to \$1,074,387.

Increase Impaired Physicians Committee by \$24,167 to \$29,167 (Impaired Physician Committee budget was increased due to testimony that a Medical Director would be hired November 1, 1988; therefore, funding is for period November 1, 1988, through May 31, 1989, based upon an *annualized* budget of \$50,000 as presented in the Minority Report);

Increase "Total Committees" by \$29,167 to \$393,640; and

Decrease "Revenue Over Expense from Regular Operations" by \$4,167 to \$6,320.

## RESOLUTION 12 MAG Dues

### Muscogee County Medical Society

*Whereas*, at the present MAG's dues billing is: 66 years of age dues reduced 20%; 67 years of age dues reduced 40%; 68 years of age dues reduced 60%; 69 years of age dues reduced 80%; 70 years of age dues exempt (tenure of membership at least ten years); and,

*WHEREAS*, many socio-economic events have made dramatic changes in the practice of medicine today; and,

*Whereas*, an appreciable number of physicians have expressed a desire to semi-retire or limit their practices prior to the magic age of 65; and,



## SUPPLEMENTAL REPORT

### Reserve for Tort Reform Activities

As of May 31, 1987, the audited balance in the Tort Reform Reserve Account was \$479,652. To date, actual expenditures chargeable to this account this year are less than \$2,500. As delineated below, the Reserve Account is expected to increase by at least \$50,420 since there are no current plans to expend substantial amounts from this reserve prior to May 31, 1988.

Audited Balance	\$479,652
5/31/87	
Receipts FY88	29,000
Projected Expenditures	(7,000)
FY88	
Projected Interest	28,420
Earnings FY88	
Projected Fund	\$530,072
Balance 5/31/88	

Whereas, the Association needs the expertise of this group of members; now, therefore, be it

RESOLVED, that anyone who has been a member in good standing of the Medical Association of Georgia continuously for at least 25 years, may be eligible for half-rate MAG dues at age 60, and dues exempt at age 65, upon request; and be it further

RESOLVED, that anyone practicing only part-time who has been a member in good standing for at least 25 years, may be eligible for half-rate dues by showing proof of part-time practice of 20 hours per week or less.

#### House Action

Adopted as amended: "Resolved 1 and 2 are referred to the Board of Directors for study. The results of the study should be presented at the September Board of Directors meeting and if a need to modify the present dues structure is perceived, appropriate direction should be given to the Constitution & Bylaws Committee so that the House of Delegates may consider action at its next meeting."

## RESOLUTION 14

### Alternate Income Study Committee

#### MAG Executive Committee

*Referred to Reference  
Committee F*

RESOLVED, that the MAG House of Delegates authorize the establishment of a study committee to evaluate possible opportunities for alternative non-dues income sources.

#### House Action

Adopted.



# Report

## Reference Committee

# C&B

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### CONSTITUTION AND BYLAWS COMMITTEE

**J. Rhodes Haverty, Jr.,  
M.D., Chairman**

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**T**he Reference Committee on Constitution and Bylaws was comprised of the following physicians: James Q. Whitaker, Chairman, Peach Belt; E. Van Herrin, Vice Chairman, Crawford B. Long; Clyde B. Roundtree, DeKalb; Frank E. Carlton, Georgia Medical Society; Chappell A. Collins, Jr., Dougherty; Sidney A. Bell, Floyd-Polk-Chattooga; Thomas J. Anderson, Jr., Medical Association of Atlanta; and Gary R. Loveless, Ogeechee River.

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**C**hapter X, Section 6 of the MAG Bylaws mandate a complete review of the Constitution and Bylaws at least once every five years with the purpose in mind that the Committee on Constitution and Bylaws will propose amendments that seem advisable.

The Committee has been engaged in a complete review of the Constitution and Bylaws during the past year. The focus of the review has been to clarify existing provisions, correct any errors or omissions, simplify the style and purpose such changes as would improve the Constitution and Bylaws and make them more efficient. The Committee's study has resulted in a number of proposed amendments which are included in the report below.

(Note: Amendments by addition are underlined, and amendments by deletion are ~~crossed-out~~.)

#### MAG CONSTITUTION

The following Constitutional amendment was introduced at the 1987 House of Delegates meeting. It has "been on the table" for the past year, published in the MAG *Journal* as required, and is now eligible to be voted on by the House.

The amendment would change the composition of the House by the addition of a voting delegate to represent the Young Physician Section.

#### **Article V — House of Delegates**

**SECTION 1. COMPOSITION.** The House of Delegates is composed of delegates elected by the component societies, the Resident Physician Section, the Young Physician Section, the Medical Student Section, and Hospital Medical Staff Section. All delegates' qualifications and terms of office shall be provided for in the Bylaws. The officers, the past presidents of the Association, the Editor of the *Journal*, delegates to the AMA, the Executive Director and chairpersons of standing committees shall be ex-officio members of the House of Delegates without the right to vote.

#### **House Action**

Adopted.





Members of the Reference Committee on Constitution & Bylaws (C&B) listen to their chairman at the podium, J. Rhodes Havery, Jr., of Atlanta.

## MAG BYLAWS

### CHAPTER II — MEMBERSHIP

#### SECTION 1. ACTIVE MEMBERS.

(a) A physician may become an Active Member in the Association if the requirements of subparagraphs (i), (ii), or (iii) below are met:

(i) A physician shall hold the degree of Doctor of Medicine or Bachelor of Medicine, or its equivalent, from a medical college acceptable to the Judicial Council of the Association, be licensed to practice medicine in the State of Georgia, and be certified by the Secretary of a component society as being a member in good standing of such component society; or

#### House Action

Section 1 (a)(i): Changed and adopted 'or its equivalent' to "or an equivalent degree issued in a foreign country."

(iii) A physician shall hold the degree of Doctor of Medicine or Bachelor of Medicine, or its equivalent, from a medical college acceptable to the Judicial Council of the Association, be certified by the Secretary of a component society as being a member in good standing of such component society and be employed as a full-time commis-

sioned medical officer in any of the armed forces of the United States or in the United States Public Health Services, Veterans Administration or Indian Service.

#### House Action

Section 1 (a)(iii): Changed and adopted "or its equivalent" to "or an equivalent degree issued in a foreign country."

(b) Those members classified under subparagraphs (i) and (iii) above shall pay full annual dues and assessments to the Association; and those members classified under subparagraph (ii) above shall pay such dues and assessments, ~~which may be less than full dues~~, as the House of Delegates upon recommendation of the Board of Directors may from time to time determine. All members described in this Section 1 shall have full privileges of membership, including the right to vote, to hold office and to receive the *Journal of the Medical Association of Georgia*, except as expressly set forth in these Bylaws. A physician applying for active membership after July 1 of any year, who is applying for membership in the Medical Association of Georgia for the first time, shall pay one-half of the annual dues set for that par-

ticular membership classification. This does not apply to any physician whose dues may be reduced under the provisions of the sliding dues schedule.

(c) An Active Member may be excused from the payment of dues or assessments ~~for the duration of either of the following circumstances:--(i) financial hardship or illness; or (ii) temporary service in the armed forces of the United States during a national emergency or compulsory service under the Selective Service System or temporary service as a full-time commissioned medical officer in any reserve service of the armed forces.~~ Such relief shall not become effective until a lapse of 90 days after application therefor at which time it will become retroactive and will extend through the applicable period. Such dues or assessments exemption may be granted or denied by the Judicial Council after recommendation of the member's component local society; ~~and the Judicial Council shall be fully empowered to grant or deny such exemption whether or not such member's constituent local society has recommended such exemption.~~ Members excused from the payment of dues or assessments pursuant to sub-



~~paragraph (c) (i) above, the above shall continue to receive all rights and benefits of membership as enjoyed by active dues paying members. Members excused from the payment of dues pursuant to subparagraph (c) (ii) above shall not receive any publication of the Association except by personal subscription.~~

~~(d) Any members who are participants in the reduced dues program shall be entitled to receive all rights and privileges of membership as enjoyed by active full dues paying members. This would also apply to those physicians classed as DE-7, who are dues exempt by reaching the end of the senior member sliding dues scale. This section shall only apply to those members categorized in Chapter II, Membership, Section 1, Active Members, and Section 7, Life Members.~~

### House Action

Section 1 (b) (c) (d): Adopted.

#### SECTION 2. RETIRED MEMBERS.

A member who elects to retire from the practice of medicine regardless of age or length of membership in this Association may do so and be classified as a retired member. Retired members shall not be requested to pay dues or assessments, nor shall they be entitled to vote, hold office or receive any publication of the Association except by personal subscription. Retired physicians shall be defined as those who have indicated their retirement in writing to the MAG Secretary and practice less than 20 hours per week.

### House Action

Section 2: Adopted.

#### SECTION 3. SERVICE MEMBERS.

A physician may become a Service Member by being a full-time commissioned medical officer in any of the armed forces of the United States or by having retired from gainful

employment as a medical officer of the United States Public Health Services, Veterans Administration, Indian Service, or Armed Forces. Service Members need not be licensed to practice medicine in the State of Georgia provided they hold the degree of Doctor of Medicine or Bachelor of Medicine, or its equivalent, from a medical college acceptable to the Judicial Council. Such members shall not be required to pay any dues or assessments to the Association. They shall not be entitled to vote or hold office in the Association, nor shall they receive any publications of the Association except by personal subscription.

### House Action

Section 3: Changed and adopted "or its equivalent" to "or an equivalent degree issued in a foreign country."

~~SECTION 4. ASSOCIATE MEMBERS. Physicians may become Associate Members of MAG when they are recommended by their component medical societies and they have met the criteria for Associate Member as established by the MAG Executive Committee. Associate Members need not be licensed to practice medicine in the State of Georgia. Associate Members may not vote nor hold office except that they may vote when serving as members of MAG committees on issues submitted to a vote of such committees.~~

### House Action

Section 3: Referred to Committee on Constitution and Bylaws.

SECTION 8. STUDENT MEMBERS. Any person certified by the Secretary of a component county medical society to be a student member thereof may, upon such certification by such Secretary, become a Student Member of this Association upon proof that such person is a student in good standing at a medical school approved by

the Composite State Board of Medical Examiners Liaison Committee on Medical Education. Student Members may not vote nor hold office except that they may vote when serving as members of MAG committees on issues submitted to a vote of such committees.

### House Action

Section 8: Adopted.

#### SECTION 13. JURISDICTION.

(a) It shall be the policy of this Association and its component county medical societies that its members shall belong to the component county medical society having jurisdiction of the county of their dominant practice. Exceptions may be granted by the Judicial Council on request from the member or members seeking an exception to this general policy, provided that the society transferred to shall be contiguous to the county of the member's dominant practice. When no such component county medical society has jurisdiction of the county in which the member has dominant practice, such member shall belong to a component county medical society having jurisdiction of a county adjacent to the county in which the member has dominant practice. ~~This shall not necessarily be retroactive.~~

(b) If physicians reside and/or practice in other states, they may belong to county medical societies in Georgia, as long as they are members of and in good standing in the state medical associations in their states of dominant practice. Such membership shall be applied for through the county medical society in Georgia with which they wish to affiliate and all business shall be conducted through that county society and not the MAG.

(c) If a member of the MAG temporarily moves to another state for continuing education, fellowship, additional residency, military service, or other reasons approved by



the member's county medical society, the member may continue membership in the MAG as long as the physician remains a member in good standing (~~dues paying or dues exempt~~) in the Georgia county medical society in which the member last practiced.

## House Action

Section 13 (a) (b) (c): Adopted.  
~~SECTION 14. DEFINITION OF "FULL TIME". The words "full time" wherever used in this Chapter shall mean that no time at all is devoted to private practice.~~

## House Action

Section 14: Adopted.  
~~SECTION 15. EXCEPTION FOR MEMBERS IN GOOD STANDING AS OF APRIL 20, 1975. A person who was accepted as a member in good standing as of April 20, 1975, shall continue as a member of the Association notwithstanding that such person may not hold the literal degree of Doctor of Medicine or Bachelor of Medicine. However, such member shall be subject to all other provisions of these Bylaws for continuation of membership.~~

## House Action

Section 15: Adopted.  
 CHAPTER IV — HOUSE OF DELEGATES

SECTION 2. COMPOSITION.  
 (a) COMPONENT COUNTY SOCIETIES. For each 25 members, or fraction thereof, whose dues have been paid to the Association by December 31 of the preceding year, each component county society shall elect one delegate and a corresponding one alternate delegate, each of whom shall have been a member in good standing of the Association for the immediately preceding three years, provided, however, that each component county society shall be entitled to at least one delegate and one alternate delegate. In arriving at the number of

delegates to be apportioned to each component society, life members, ~~DE-1's and DE-7's~~ shall be counted the same as dues paying members and included in the total for purposes of delegate apportionment. Delegate entitlement will be determined by counting only those physicians who are actually members of a component society and MAG on December 31 of the year preceding the annual session during which the apportionment would be in effect. Delegates to the House of Delegates shall serve for a term of three years, with one-third of the members of the House of Delegates to be elected annually, provided that component county societies which are entitled to three or more delegates shall elect at their first election one-third of their delegation for a term of one year, one-third of their delegation for a term of two years, one-third of their delegation for a term of three years and thereafter elect such delegates whose terms of office expire therewith. Those component county societies which are entitled to less than three delegates shall elect their delegate or delegates for staggered terms in rotation in such manner as may be determined by the Board of Directors, until one-third of the House of Delegates is being elected annually.

## House Action

Chapter IV, Section 2 (a): Adopted.

### (b) SECTIONS

(i) The Hospital Medical Staff Section shall be comprised of active members of the staff of any duly licensed hospital in Georgia, who holds an M.D. degree or its equivalent and who has an unrestricted license to practice medicine and surgery in Georgia, and is a member in good standing of the Medical Association of Georgia. The Section shall be entitled to one voting delegate and one alternate delegate

who shall be elected each year by the Section.

~~The Medical Staff Section shall be entitled to one voting delegate and alternate delegate. These delegates shall be elected each year by the Section and shall be members in good standing with the Medical Association of Georgia.~~

(ii) The Resident Physician Section shall be comprised of physicians who are serving in Georgia Residency Training programs approved by the Accreditation Council for Graduate Medical Education and who are members in good standing of the Medical Association of Georgia. The Section shall be entitled to one voting delegate and one alternate delegate who shall be elected each year by the Section.

~~The Resident Physician Section shall be entitled to one voting delegate and alternate delegate. These delegates shall be elected by the Section and shall be members in good standing with the MAG.~~

## House Action

Section 2 (b) (i) (ii): Adopted.  
 (iii) The Medical Student Section shall be comprised of medical students who are Student Members of the Medical Association of Georgia, enrolled in Georgia medical schools that are accredited by the Liaison Committee on Medical Education. The Section shall be entitled to one voting delegate and one alternate delegate who shall be elected each year by the Section.

~~One student representative each from the medical schools in Georgia which are accredited by the Liaison Committee on Medical Education shall be a member of the House of Delegates without the power to make motions or to vote, but with the right to be heard at meetings.~~



## House Action

Section 2 (iii): Adopted as amended:

“(iii) The Medical Student Section shall be comprised of medical students who are student members of the Medical Association of Georgia, enrolled in Georgia medical schools that are accredited by the Liaison Committee on Medical Education. The Section shall be entitled to one student representative from each of the medical schools in Georgia which are accredited by the Liaison Committee on Medical Education each of whom shall be a member of the House of Delegates without the power to make motions or to vote, but with the right to be heard at meetings.”

(iv) The Young Physicians Section shall be comprised of those active members of the Medical Association of Georgia who are under 40 years of age or within the first

five years of medical practice and are not residents. The Section shall be entitled to one voting delegate and one alternate delegate who shall be elected annually by the Section from among its members.

Notwithstanding any deadline established for the introduction of resolutions to the House of Delegates, ~~the Medical Staff Section and the Resident Physician Section~~ the Sections authorized in the Constitution shall have the right to adopt resolutions at their meetings immediately preceding the House of Delegates and to have their resolutions introduced at the opening session of the House.

## House Action

Section 2 (iv): Adopted.

SECTION 6. GENERAL ORDER OF BUSINESS. The following shall be the general order of business at all meetings of the House of Dele-

gates: (1) call to order by the Speaker; (2) roll call; (3) elections of ~~Speaker and Vice Speaker every~~ third year; (4) reading and adoption of minutes; (5) reports of officers; (6) reports of committees; (7) unfinished business, and (8) new business. At any meeting, the House by majority vote may change the order of business. New business may be introduced at the final meeting of the House of Delegates only when such business is of an emergency nature or introduced by unanimous consent.

## House Action

Section 6: Adopted.

## CHAPTER V — BOARD OF DIRECTORS

### SECTION 1. COMPOSITION.

(b) Directors and Alternate Directors are selected as follows:

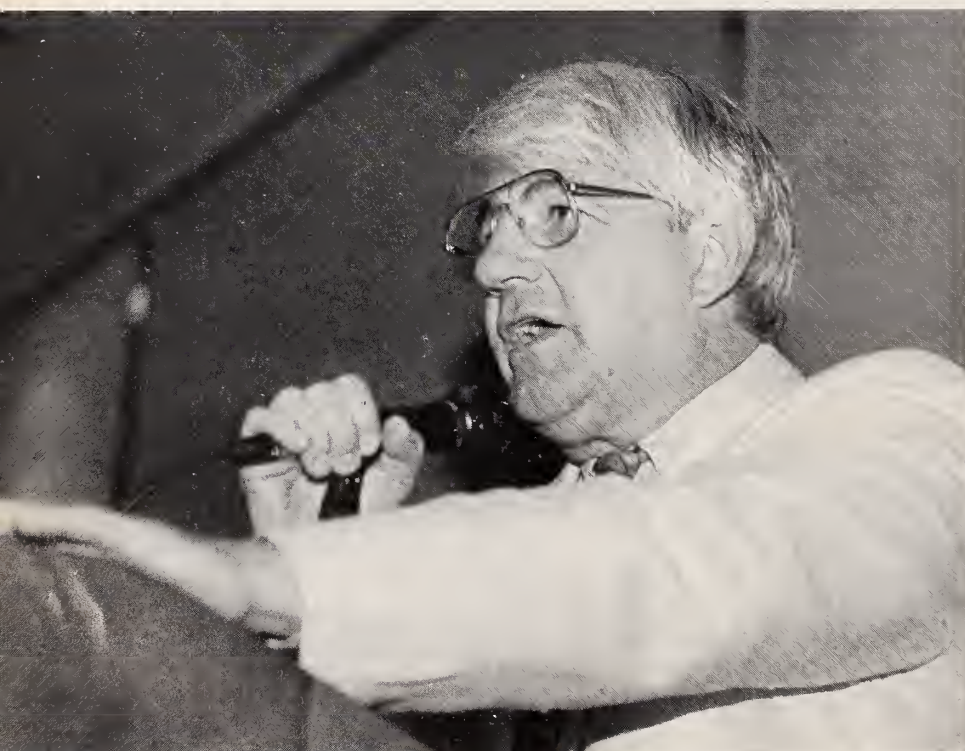
(i) Subject to the provisions of subsequent subparagraphs of this Section, each component county medical society having the requisite number of active members (who are not in arrears in the payment of dues to the Association) and Life Members, as indicated in the following table, shall be entitled to have the indicated numbers of Directors and Alternate Directors directly representing each such society:

<i>Number of Active Members</i>	<i>Number of Directors and Alternate Directors</i>
100-399	1
400-999	2
1,000 or more	3
1,000-1,499	3
1,500-1,999	4
2,000 or more	5

## House Action

Chapter V, Section 1 (i): Adopted as amended:

“(i) Subject to the provision of subsequent subparagraphs of this Section, each component county



*Dr. William C. Collins, of Atlanta, Chairman of MAG's Board of Directors.*



medical society having the requisite number of active members (who are not in arrears in the payment of dues and assessments to the Association), as indicated in the following table, shall be entitled to have the indicated numbers of Directors and Alternate Directors directly representing each such society.”.

## SECTION 2. ELECTION OF DIRECTORS AND ALTERNATE DIRECTORS.

(c) If a Director dies, resigns, or is unable to fill effectively the office of Director because of physical incapacity, he shall be succeeded in such office until the next Annual Session by the Alternate Director of the District Society or the component county medical society which he represents. If an Alternate Director dies, resigns or is unable to fill effectively the office of Alternate Director because of physical incapacity, or is serving as Director pursuant to the provisions of the immediately preceding sentence of this Section, until the next Annual Session, the person to fill the vacancy so created shall be the president, vice-president or secretary in that order of succession, of the district society or the component county medical society which the Alternate Director whose office is being filled represented, provided that if the first such officer in the order of succession is already serving as Director or declines to serve, then the next succeeding officer in line of succession shall serve as Alternate Director until the next Annual Session. Both the new Director and Alternate Director shall only serve until the next Annual Session at which time notice of election from the district society or the component county medical society will be presented to fill out the balance of the terms for which the original Director or Alternate Director was elected. Such interim notices of election shall be forwarded in like

manner as regular notices of election for Director and Alternate Director. In the absence of such timely notices of election, such interim elections for the balance of such terms shall be filled by the members of the House of Delegates at the Annual Session. Directors shall not serve more than three consecutive three-year terms. Alternate Directors shall not serve more than three consecutive three-year terms.

## House Action

Section 2 (c): Adopted as amended by the deletion of, “Directors shall not serve more than three consecutive three-year terms. Alternate Directors shall not serve more than three consecutive three-year terms.”

## SECTION 4. EXECUTIVE COMMITTEE.

(c) General Duties. (i) The Executive Committee shall make recommendations to the Board of Directors and shall carry out such items of business as are referred to it; (ii) the Executive Committee shall appoint all Association committees, including chairpersons; (iii) the Executive Committee shall nominate members of all boards required by the law of the State of Georgia on recommendation of the district societies where applicable or not otherwise provided for, all such recommendations being subject to confirmation by the Board of Directors; (iv) the Executive Committee shall serve as Publications Committee of the *Journal*; (v) the Executive Committee shall recommend to the Board of Directors the terms of employment and salaries of all personnel necessary to conduct the affairs of the Association; (vi) the Executive Committee shall be empowered to select an Executive Director who shall be responsible to the Executive Committee and for the operations of the Headquarters Office, subject to the ap-

proval of the Board of Directors; (vii) the Executive Committee between meetings of the Board of Directors shall have the authority and power of the Board of Directors ~~in the field of legislative activity~~; and (viii) the Executive Committee shall act as a Board of Trustees, directing the Executive Director in carrying out the mandates and policies of the Board of Directors and the House of Delegates. (Between meetings of the Executive Committee, the Chairman of the Executive Committee of the Board of Directors or the Chairman’s duly appointed representative shall direct the Executive Director as to undetermined matters of policy.)

## House Action

Section 4: Adopted.

SECTION 8. DUTIES OF DIRECTORS AND ALTERNATE DIRECTORS. Each Director shall be organizer, peace-maker, and censor for the district represented by the respective Director. The Director shall visit each county in the respective district at least once a year for the purpose of organizing component societies where none exists, for inquiring into the conditions of the profession, and to keep in touch with the activities of, and to aid in the betterment of, the component societies in that district. The Director shall make an annual report at the Annual Session of the House of Delegates, listing all eligible physicians in the respective district who are not members of a component society and describe the work and the condition of the profession of each county in that district. The Alternate Director shall assist the Director in the performance of duties.

## House Action

Section 8: Adopted.



## CHAPTER VII — RIGHTS AND DUTIES OF OFFICERS

**SECTION 3. IMMEDIATE PAST PRESIDENT.** The Immediate Past President shall serve as Immediate Past President for a term of one year following the term of office as President and as such shall serve on the Board of Directors and its Executive Committee. The following two years the Immediate Past President shall continue to serve as a member of the Board of Directors. ~~The foregoing shall be retroactive where it applies.~~

### House Action

Chapter VII, Section 3: Adopted.

## CHAPTER VIII — COMPONENT COUNTY SOCIETIES

**SECTION 3. CHARTER.** ~~The Board of Directors~~ House of Delegates shall provide and issue charters to county medical societies organized to conform to the Association's Constitution and Bylaws. Such charter shall be signed by the President and the Secretary. The House of Delegates shall have authority to revoke the charter of any component county society whose actions are in conflict with the letter or spirit of the Association's Constitution and Bylaws. Only one component county medical society shall be chartered in each county. The charter of any component county society shall stand automatically revoked as of February 1 of the next calendar year following 12 consecutive full calendar months when the total dues forwarded to the Association shall total less than five members. Any society whose charter is thus automatically removed may apply for a new charter by following the procedures established in SECTION 1 of this CHAPTER VIII.

### House Actions

Chapter VIII, Section 3: Adopted.

## SECTION 4. NAMES OF SOCIE-

**TIES.** The names and titles of each component county society shall read exactly as found in its charter. No change in such names shall be made without the approval of the ~~Board of Directors~~ House of Delegates of the Medical Association of Georgia.

### House Action

Section 4: Adopted.

**SECTION 9. COMBINED COUNTIES.** In sparsely geographic ~~populated~~ areas, the ~~Board of Directors~~ House of Delegates shall have authority to organize the physicians of two or more counties into societies, to be suitably designated so as to distinguish them from district societies. These societies when chartered shall be entitled to all the rights and privileges provided for component societies. A physician residing in a county not having a component society shall be referred to an adjacent component county society by the Board of Directors.

### House Action

Section 9: Adopted.

~~SECTION 12. RESIDENT PHYSICIAN SECTION.~~ The Resident Physician Section is composed of Resident members of the Association who are serving in approved training programs in the State of Georgia. The functions and structure of this resident business section shall be formulated by the MAG Board of Directors.

### House Action

Section 12: Adopted.

## CHAPTER IX — FUNDS AND EXPENDITURES

**SECTION 2. DUES AND ASSESSMENTS.** The annual dues and assessments shall be determined by the House of Delegates upon recommendation of the Board of Directors and shall be levied per capita on the active members of the

Association. ~~They shall be payable to on or before January 1st of the year for which they are levied in accordance with the following procedures: They shall be paid no later than December 31 of the year in which they are levied, unless a different due date is specified in the resolution adopted by the House of Delegates.~~

### House Action

Chapter IX, Section 2: Adopted as amended by deleting the last sentence and inserting the following:

"They shall be payable on or before January 1st of the year for which they are established by the House of Delegates when setting the next fiscal year's budget, unless a different due date is specified in the resolution adopted by the House of Delegates. Dues shall be paid in accordance with the following procedures:"

(a) All active members of the Association who are also members of component county societies, other than those described in subsection (b) hereof, shall pay such dues and assessments in accordance with the following procedures: The Secretary of each component society shall certify each year, on the date specified by the Secretary of the Association, its correct mailing addresses, and the amount of dues and assessments for the next calendar year to be levied on its members pursuant to the constitution and bylaws of the component county society. The Secretary of the Association shall bill such members for dues and assessments due the Association, the American Medical Association, and the particular component county society and collect all such dues and assessments. Within 60 days of receipt of such dues or assessments, the Secretary of the Association shall remit to the secretary of the particular component county society all component county society dues and assess-



ments collected by such date from its members. The Secretary of the Association shall remit to the American Medical Association all dues and assessments thus collected for it. ~~Any member whose dues and assessments to the Association have not been paid for the current year on or before April 1st shall stand suspended until that member's dues and assessments for the current year have been paid.~~

(b) All active members of the Association who are also members of a component society which, through its appropriate officers, has certified to the Secretary of the Association that, with respect to a particular calendar year, the component society elects to be governed by this subsection (b), shall pay dues and assessments in accordance with the following procedure: the secretary of such component county society shall cause to be collected and shall forward to the office of the Association the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues and assessments for the current year have not been remitted to the headquarters office of the Association on or before April 1st of the following year shall stand suspended until his name is properly reported and his dues and assessments for the current year properly remitted.

## House Action

Chapter IX, Section (a) (b): Adopted.

~~(c) An active member who fails to pay dues for one year may be reinstated without re-application upon payment of the current year's dues, provided there is no objection by the respective county medical society. Any member failing to pay dues for more than one year shall be eligible for reinstatement~~

~~upon payment of dues for the current year, subject to re-application to and approval of the respective county medical society.~~

(c) Any member whose dues and assessments to the Association have not been paid for the current year on or before April 1st shall stand suspended. Such member or members may be automatically reinstated provided all dues and assessments are paid no later than December 31st of that year. An active member who fails to pay dues and assessments for one or more consecutive years may be reinstated upon reapplication subject to approval by the respective county medical society and upon payment of the current year's dues and assessments plus the dues and assessments for the year immediately preceding.

## House Action

Chapter IX, Section (c): Adopted as amended by deleting the word "current" in the first sentence and inserting in lieu thereof the words "annual membership dues," and inserting between the words "1st" and "shall" in the first sentence the words "of that year."

(d) A physician transferring to the Medical Association of Georgia from another state medical association shall be excused from paying current dues and assessments provided all dues and assessments to the state association from which the physician transferred have been paid.

## House Action

Chapter IX, Section (d): Adopted.

## CHAPTER XV — RULES AND ETHICS

SECTION 2. PROCEDURE. The deliberations of the Association shall be conducted in accordance with parliamentary usage contained in the then current edition of Sturgis Standard Code of Parlia-

mentary Procedure Robert's Rules of Order, unless contrary to the Association's Constitution and Bylaws.

## House Action

Chapter XV, Section 2: Adopted as amended by adding after the words "Robert's Rules of Order," the words "newly revised."

## CHAPTER XVI — AMENDMENTS

SECTION 1. AMENDMENTS. These Bylaws may be amended at any Annual Session by a majority vote of the House of Delegates after the amendment has lain on the table for one day.

Amendments to these Bylaws or to the Constitution may be proposed by action of the House of Delegates, or by the Board of Directors, or the Executive Committee of the Board of Directors, or by the Committee on Constitution and Bylaws, or by any group of active members numbering five or more. Proposed amendments must be submitted to and received by the Constitution and Bylaws Committee not less than ~~seventy-five (75)~~ forty-five (45) days prior to the Annual Session at which they are to be acted upon. In an emergency situation and upon the affirmative vote of two-thirds of the Board of Directors, a meeting of the Constitution and Bylaws Committee shall be called to consider additional amendments to the Constitution and Bylaws following the expiration of the normal amendment introduction period ending ~~seventy-five (75)~~ forty-five (45) days prior to the Annual Session.

## House Action

Chapter XVI, Section 1: Adopted.



### SUPPLEMENTAL REPORT A CONSTITUTION AND BYLAWS COMMITTEE

J. Rhodes Haverty, Jr.,  
M.D., Chairman

**A**s a part of its five year review of the Constitution and Bylaws, the Committee proposes the following Constitutional amendments. If these amendments are received by the House at the 1988 meeting, they will "lay on the table" until the 1989 House of Delegates meeting at which time they will be formally presented for approval or rejection.

(Note: Amendments by addition are underlined, and amendments by deletion are ~~crossed-out~~.)

#### ARTICLE V — HOUSE OF DELEGATES

SECTION 1. COMPOSITION. The House of Delegates is composed of delegates elected by the component societies in such number as determined by the Bylaws; the Resident Physician Section, the Medical Student Section, and Hospital Medical Staff Section. All delegates' qualifications and terms of office shall be provided for in the Bylaws. The officers, the past presidents of the Association, the Editor of the *Journal*, delegates to the AMA, the Executive Director and chairpersons of standing committees shall be ex-officio members of the House of Delegates without the right to vote.

#### ARTICLE V — BOARD OF DIRECTORS

SECTION 1. COMPOSITION. The Board of Directors is composed of the President, the President-elect, the Immediate Past President, the

two preceding immediate past presidents, two vice presidents, Secretary, Treasurer, Speaker of the House of Delegates and Directors as provided for in the Bylaws. Delegates and Alternates Delegates to the AMA, Association members who are past presidents of the AMA, Editor of the *Journal*, past presidents other than the three immediate past presidents and the Executive Director shall be ex-officio members of the Board of Directors without the right to vote. Alternate Directors shall be ex-officio members except in the absence of their respective Directors as provided for in the Bylaws. The Vice Speaker shall be an ex-officio member except in the absence of the Speaker as provided for in the Bylaws.

#### ARTICLE X — FUNDS AND EXPENDITURES

Funds for the Operation of the Association shall be raised ~~by an equal per capita assessment on the members of each component society as determined by the Bylaws~~. The amount of assessment shall be set by the House of Delegates upon recommendation of the Board of Directors. Funds may also be raised by voluntary contributions, from the Association's publications, and in any other manner approved by the Board of Directors. The Board of Directors shall submit an annual budget to the House of Delegates and shall manage the finances of the Association.

#### ARTICLE XI — OFFICIAL PUBLICATION

The Official publication of the Association shall be the *Journal of the Medical Association of Georgia*, ~~in which shall be published all official Association notices, abstracts of transactions of the House of Delegates, and general meetings of the Association, the annual budget, complete financial reports as directed by the Board of Directors and~~

~~abstracts of meetings of the Board of Directors.~~

#### House Action

Proposed constitutional amendments in this Report were received by the House to lie on the table and be presented for a vote at the next session of the House of Delegates.

### SUPPLEMENTAL REPORT B CONSTITUTION AND BYLAWS COMMITTEE

J. Rhodes Haverty, Jr.,  
M.D., Chairman

**R**esolution 2 introduced at the 1988 Annual Session requests the House of Delegates to amend the MAG Constitution and Bylaws so that Doctors of Osteopathy may qualify for membership in the Medical Association of Georgia.

The Committee on Constitution and Bylaws is divided on the question of whether or not membership should be available to Osteopaths. The Chairman of the Committee, however, feels that the House of Delegates should have at its disposal the means by which to implement the intent of Resolution 2 if it is the will of the House to do so.

Without recommendation, therefore, the Committee offers the following series of amendments to that end:

(Note: Amendments by addition are underlined, and amendments by deletion are ~~crossed-out~~.)

#### CHAPTER II — MEMBERSHIP SECTION 1. ACTIVE MEMBERS.

(a) A physician may become an Active Member in the Association if the requirements of subpara-



graphs (i), (ii), or (iii) below are met:

(i) A physician shall hold the degree of Doctor of Medicine, Doctor of Osteopathy or Bachelor of Medicine, or its equivalent, from a medical college acceptable to the Judicial Council of the Association, be licensed to practice medicine in the State of Georgia, and be certified by the Secretary of a component society as being a member in good standing of such component society; or

(ii) A physician shall hold the degree of Doctor of Medicine, Doctor of Osteopathy, or Bachelor of Medicine, or its equivalent, from a medical college acceptable to the Judicial Council of the Association, and be employed as an intern or resident in a hospital whose internship program is approved by the Composite State Board of Medical Examiners of Georgia or any predecessor or successor body authorized to license Doctors of Medicine, and be certified by the Secretary of a component society as being a member in good standing of such component society; or

(iii) A physician shall hold the degree of Doctor of Medicine, Doctor of Osteopathy, or Bachelor of Medicine, or its equivalent, from a medical college acceptable to the Judicial Council of the Association, be certified by the Secretary of a component society as being a member in good standing of such component society and be employed as a ~~full-time~~ commissioned medical officer in any of the armed forces of the United States or in the United States Public Health Services, Veterans Administration or Indian Service.

## House Action

Chapter II, Section 1 (a) (i) (ii) (iii): Adopted.

### SECTION 3. SERVICE MEMBERS.

A physician may become a Service Member by being a ~~full-time-com-~~

missioned medical officer in any of the armed forces of the United States or by having retired from gainful employment as a medical officer of the United States Public Health Services, Veterans Administration, Indian Service, or Armed Forces. Service Members need not be licensed to practice medicine in the State of Georgia provided they hold the degree of Doctor of Medicine, Doctor of Osteopathy or Bachelor of Medicine, or its equivalent, from a medical college acceptable to the Judicial Council. Such members shall not be required to pay any dues or assessments to the Association. They shall not be entitled to vote or hold office in the Association, nor shall they receive any publications of the Association except by personal subscription.

## House Action

Section 3: Adopted.

SECTION 7. MEDICAL STUDENT MEMBERS. Any person certified by the Secretary of a component county medical society to be a student member thereof may, upon such certification by such Secretary, become a Student Member of this Association upon proof that such person is a student in good standing at a medical school approved by the ~~Composite State Board of Medical Examiners~~ Liaison Committee on Medical Education or the Committee on Colleges, Bureau of Professional Education, American Osteopathic Association. Student Members may not vote nor hold office except that they may vote when serving as members of MAG committees on issues submitted to a vote of such committees.

## House Action

Section 7: Adopted

## CHAPTER IV — HOUSE OF DELEGATES

### SECTION 2. COMPOSITION. (b) SECTIONS.

(i) The Hospital Medical Staff Section shall be comprised of active members of the staff of any duly licensed hospital in Georgia, who hold a D.O. degree or an M.D. degree or its equivalent and who have an unrestricted license to practice medicine and surgery in Georgia, and are members in good standing of the Medical Association of Georgia. The Section shall be entitled to one voting delegate and one alternate delegate who shall be elected each year by the Section.

(ii) The Resident Physician Section shall be comprised of physicians who are serving in Georgia Residency Training programs approved by the Accreditation Council for Graduate Medical Education, or by the American Osteopathic Association, and who are members in good standing of the Medical Association of Georgia. The Section shall be entitled to one voting delegate and one alternate delegate who shall be elected each year by the Section.

## House Action

Chapter IV, Section 2 (b) (i) (ii): Adopted.

## RESOLUTION 1

### Number of Directors: Bylaws Amendment

**Thomas J. Anderson, Jr.,  
M.D.**

**Linton H. Bishop, M.D.**

**George W. Jones, M.D.**

**Joseph S. Wilson, M.D.**

**Ronald N. Cook, M.D.**

**Teresa E. Clark, M.D.**

**James A. Kaufmann, M.D.**

*Whereas*, the Medical Association of Atlanta has experienced rapid growth in the last two years and now has more than 2,000 members; and,



Whereas, this has resulted in MAA's being underrepresented on the Board of Directors; now, therefore, be it

RESOLVED, that CHAPTER V, SECTION 1, (b) (i) of the Bylaws be amended to read as follows: (new language underlined):

"CHAPTER V — BOARD DIRECTORS

## SECTION L. COMPOSITION

(b) Directors and Alternate Directors are selected as follows:

(i) (a) Subject to the provisions of subsequent paragraphs of this Section, each component county medical society having the requisite number of active and life members indicated in the following table, shall be entitled to have the indicated numbers of Directors directly representing each such society:

<i>Number of Active Members</i>	<i>Number of Directors and Alternate Directors</i>
100-399	1
400-999	2
1,000 or more - <u>1,499</u>	3
<u>1,500-1,999</u>	4
<u>2,000 or more</u>	5

(b) In component medical Societies entitled to 4 or 5 Directors and Alternate Directors, each shall be designated Director or Alternate Director Number 4 or 5 accordingly. In the event that the required number of active members drops below either category of 1,5000 or 2,000 members, respectively, then the designated numbered Director and Alternate Director shall automatically be dropped from the Board of Directors at the next convening of the Annual Session."

and be it further,

RESOLVED, that it is the intent of the House of Delegates that those component medical societies affected by this amendment would be expected to conduct an election and certify the results of that election to the Secretary of MAG not later than

thirty (30) days following adjournment of the House of Delegates.

## House Action

First Resolved filed. Second Resolved adopted.

## RESOLUTION 2

### Membership of Osteopaths in MAG

**George R. Brahn, M.D.  
Norman E. Worsley, M.D.  
James Q. Whitaker, M.D.  
V. W. McEver, Jr., M.D.  
F. Hunt Sanders, M.D.**

Whereas, Doctors of Osteopathy have been allowed membership in the American Medical Association; now, therefore, be it

RESOLVED, that the Committee on Constitution and Bylaws of the Medical Association of Georgia should formulate the language necessary to amend the Constitution and Bylaws of the Medical Association of Georgia such that Doctors of Osteopathy should be allowed membership in the Medical Association of Georgia.

## House Action.

Filed.

## RESOLUTION 3

### MAG Medical Student Section Voting Delegate

**James Q. Whitaker, M.D.  
J. R. Manning, M.D.  
Carl L. Crawford, M.D.  
V. W. McEver, Jr., M.D.  
Daniel O. Fussell, M.D.**

**B**ecause we consider the following proposal to be worthy of consideration, we, the undersigned, being members of the Peachbelt Medical Society, do submit the following:

TO WIT:

Whereas, the Medical Student Section of the Medical Association of Georgia was officially established by the House of Delegates in 1984 in order to increase student involvement in organized medicine; and,

Whereas, the MAG Medical Student Section is presently represented in the House of Delegates by one non-voting representative from each of Georgia's four medical schools, who may speak at House sessions but may not introduce resolutions; and,

Whereas, the American Medical Association House of Delegates has recognized the importance of full voting privileges as essential to involvement in House proceedings, and has accordingly granted representation to the AMA Medical Student Section in the form of one Delegate and Alternate Delegate; now, therefore, be it

RESOLVED, that the Medical Association of Georgia Constitution and Bylaws shall be amended to provide for one voting Delegate and Alternate Delegate from the MAG Medical Student Section in the House of Delegates.

## House Action

Filed.



## RESOLUTION 4

### Constitution and Bylaws Amendments — 45 Day Prior Receipt

James Q. Whitaker, M.D.  
J. R. Manning, M.D.  
Carl L. Crawford, M.D.  
V. W. McEver, Jr., M.D.  
Daniel O. Fussell, M.D.

**B**ecause we consider the following proposal to be worthy of consideration, we, the undersigned, being members of the Peachbelt Medical Society, do submit the following:  
TO WIT:

An amendment to CHAPTER XVI, SECTION 1 AMENDMENTS by changing from 75 days to 45 days the time period required for receipt of proposed amendments prior to the convening of the Annual Session at which the amendment is to be acted upon, so that CHAPTER XVI, SECTION 1 will read as follows:

RESOLVED, that "Amendments to these bylaws or to the Constitution may be proposed by action of the House of Delegates, or by the Board of Directors, or the Executive Committee of the Board of Directors, or by the Committee on Constitution and Bylaws, or by any group of active members numbering five or more. Proposed amendments must be submitted to and received by the Constitution and Bylaws Committee not less than forty-five (45) days prior to the Annual Session at which they are to be acted upon. In an emergency situation and upon the affirmative vote of two-thirds of the Board of Directors, a meeting of the Constitution and Bylaws Committee shall be called to consider additional amendments to the Constitution and

Bylaws following the expiration of the normal amendment introduction period ending forty-five (45) days prior to the Annual Session."

#### House Action

Filed.

## RESOLUTION 7

### Admission of Doctors of Osteopathy to Medial Association of Georgia

#### Camden-Charlton Medical Society

*Whereas*, Doctors of Osteopathy are not presently members of the Medical Association of Georgia, and,

*Whereas*, said Doctors of Osteopathy must undergo the same medical training as Medical Doctors, and,

*Whereas*, said Doctors of Osteopathy are eligible for the same privileges at all hospitals as medical doctors, and,

*Whereas*, said Doctors of Osteopathy must undergo the same Georgia State Board of Medical Examiners, and,

*Whereas*, a Doctor of Osteopathy is presently on the Georgia State Board of Medical Examiners, and,

*Whereas*, it is altogether fitting and proper that said Doctors of Osteopathy should be members of this Association, and,

*Whereas*, this Association desires that said Doctors of Osteopathy be members of this Association, and,

*Whereas*, Doctors of Osteopathy are admitted to the membership in 46 out of 50 state associations, now, therefore, be it

RESOLVED, that Doctors of Os-

teopathy are hereby declared to be eligible to become members of the Medical Association of Georgia in accordance with the existing Bylaws which govern membership in said Association, and Bylaws now in effect in conflict with this Resolution are hereby amended to this extent, but no further.

#### House Action

Filed.



# GaMPAC Breakfast



*State Representative Dorothy Felton was honored for her continued support of physicians with MAG's Certificate of Appreciation, presented at the GaMPAC Breakfast. Dr. James Kaufmann made the presentation.*





*The head table of the GaMPAC Breakfast, Friday morning. Dr. Joe Nettles, of Savannah, addresses those present.*



*Jim Parnell, a State Representative, is presented with a Certificate of Appreciation by Dr. James Kaufmann.*



## GamPAC Breakfast

*The GaMPAC Breakfast was well attended, despite the early hour and heavy work schedule of the delegates.*







*"Won't you come home Joe Bailey!" was sung by Jana Hall of the Richmond County Auxiliary to the President-Elect, Joseph Bailey, M.D., of Augusta. Those attending the breakfast were wonderfully entertained by the song and accompanying antics.*



# Final General Session

# Installation Ceremony

Saturday, April 30

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## Welcome

**A**s Speaker of the Medical Association of Georgia's House of Delegates, Dr. Kaufmann welcomed those in attendance to MAG's first installation ceremony. This ceremony was created in an effort to present the Presidents' addresses and the formal installation of officers in a conjoint ceremony, conveniently scheduled for all members, auxiliaries and guests to attend. This ceremony proceeded the Annual President's Reception and Dance.

The Installation Ceremony provided a unique opportunity for all attendees of the House to take part in the crucial transfer of leadership within the Association.

## Invocation

Father Patrick Bright, Assistant Rector of St. John's Episcopal Church in Savannah, delivered the invocation.

## Patriotic Medley

Miss Courtenay Collins sang a patriotic medley, accompanied on piano by Mr. Jim Amend.

## President's Introduction

Speaker Kaufmann introduced MAG's outgoing President, Dr. Jack F. Menendez, with much pride and admiration, as an exceptional leader of this Association over the past year. Through his guidance, and the help of his lovely wife, Connie, MAG had an extraordinary year in every respect. His untiring leadership on major issues and policies established high standards for the leadership of this Association.

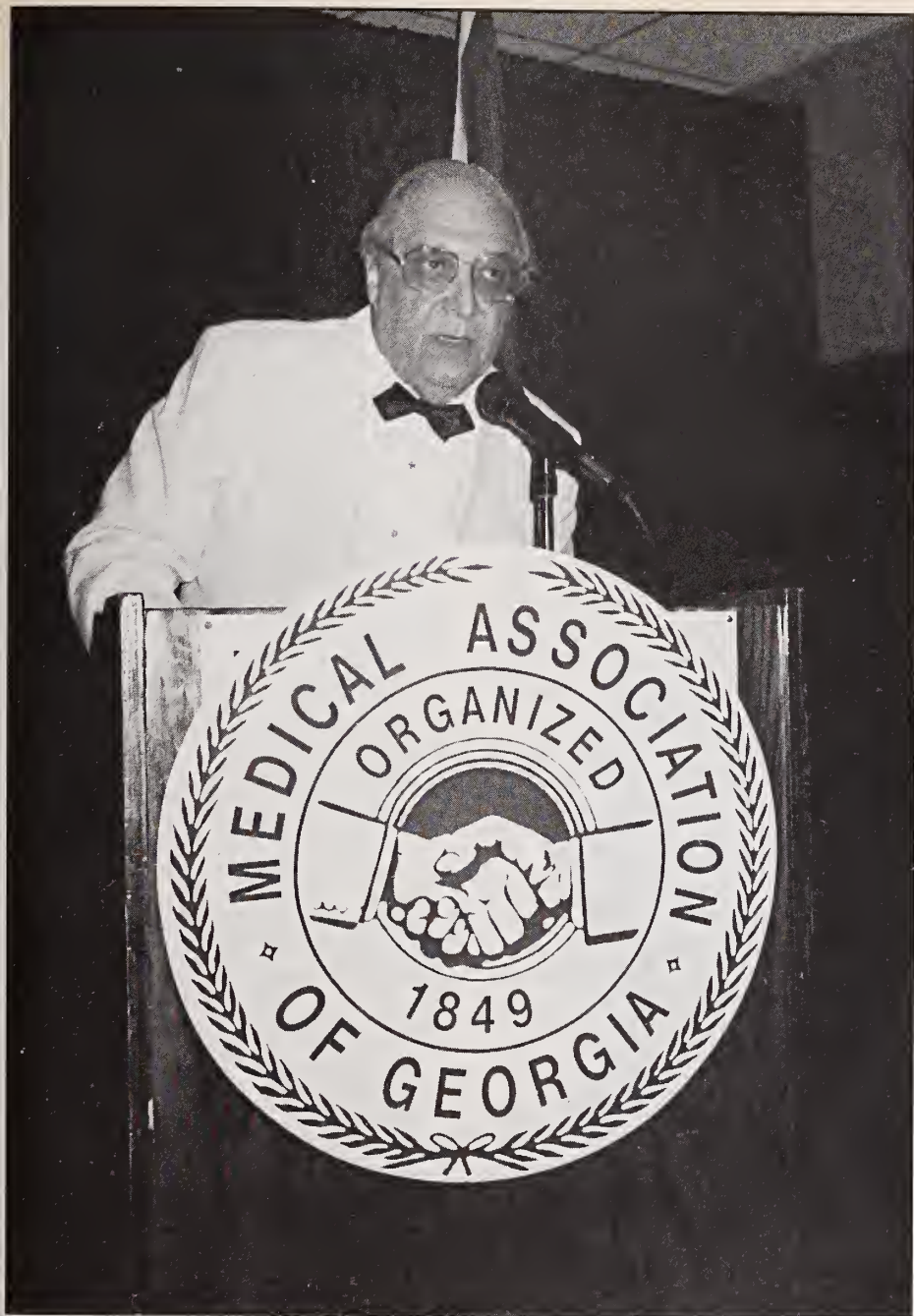
## Farewell Address

Jack F. Menendez, M.D., President, Medical Association of Georgia, 1987-88, addressed those present with the following remarks:

"Mr. Speaker, fellow delegates, ladies and gentlemen: When I stood before you a year ago, I stated that patient advocacy and unity were two worthy goals our Association should strive for to make the 'medical universe' friendly for our fellow physicians. Today, I stand before you again and ask, 'How well did *we* practice what *I* preached?' Let us look at the record together.

"Our patient advocacy efforts in the area of AIDS were clearly suc-





*Dr. James Kaufmann, Speaker of the House, welcomed those in attendance to MAG's first Installation Ceremony. This ceremony was created in an effort to present the outgoing and incoming Presidents' addresses and the formal installation of officers in a conjoint ceremony.*

cessful. We formed a statewide AIDS committee, composed of experts in the field. This committee developed an AIDS Policy Statement which directed that efforts be made in the area of education and legislation. Working closely with our auxiliary, we have sponsored public forums on AIDS over the state. We have available slides and videos for education of both the public and physicians. We also worked closely with the legislature to develop a comprehensive AIDS bill. This bill passed the legislature and has been signed into law by the Governor.

"Another major patient advocacy effort, the Healthy Lifestyles Campaign, has not progressed as far. Due to slow development and the fact that some of the funds intended for Healthy Lifestyles went instead to the AIDS effort, Healthy Lifestyles did not complete its mission. We have completed a video and some brochures, the effort will proceed further this year.

"Our *Journal* has become an outstanding part of MAG under the editorial guidance of Dr. Charles Underwood. The timeliness of the information such as the issues on AIDS, the covers, the format — all

are first class. We can all be proud of our *Journal*.

"We have other patient advocacy projects, both by MAG and by our auxiliary. This year we need special effort in the area of senior citizen advocacy. Medicare seems destined to put ever-increasing constraints on both patient and physician. We must become genuine senior citizen advocates. This position will be our best defense against onerous changes in Medicare reimbursement, such as Mandatory Assignment, RBRVS, Capitation, and other, as yet unrevealed options. There are other areas of patient advocacy efforts we could discuss, these are just some of the highlights. If we, the physicians, are not our patient's advocate, there are many others willing to assume that role; hospitals, government, senior citizen groups, and others. They are all clamoring to become our patient's advocate.

"Let us now examine the area of unity under which we can define several subheadings. The first is organizational unity. We have excellent unity within our association, a good staff, and excellent staff-physician relations. We have also been working closely with other related organizations such as MAG Mutual, the Georgia Hospital Association, and the Georgia Pharmaceutical Association, to name just three. In the area of legislation, let us separate legislative success from legislative unity. Thanks to the ability and commitment of our legislative lobbying team, we were quite successful at the capitol. A combination of 18-hour days, just 15 on weekends, innovative approaches, and plain hard work made this legislative session more successful than we had any right to expect.

"Our legislative unity is another matter, although we were able to achieve successes in the legislative arena, our lack of unity make them much harder to come by. There were six specialty PACS at the Capitol this year, the most ever. A leg-



## Final General Session-Installation Ceremony



*Miss Courtney Collins sang a patriotic medley, accompanied on the piano by Mr. Jim Amend.*

islator who has two or more groups of physicians talking to him about the same issue might well become confused. If he is so inclined, he can use our disunity against us. We must strive for unity in our legislative approach. The most dedicated opponents to quality health care stand ready to exploit any perceived disunity on our part. We have only to remember that the National Health Service was only put in place in Great Britain by driving a wedge between specialists and family physicians. Distrust between the two groups persists to this day. This black mark and lack of legislative unity must be erased.

"I stand before you fully convinced that our Association remains capable and resourceful, ready to deal with any legislative problem that comes before us. Let us speak with but one voice to our legislator.

"I want to thank everyone who has worked hard for our Association this year. Your work has made our Association function well. I will start by thanking my wife, Connie, for all she has done for me and for our Association this year. I want to lead a round of applause for her.

"I would also like to thank Mrs. Maureen Vandiver and our Auxiliary for the fantastic job they have done this year. Your anti-smoking efforts, your child-abuse programs, the Legislative Phone Bank, and much more. It all adds up to a job well done.

"I would also like to thank our capable staff for all their help, our fine CEO, Mike Fowler, and his boss, Millie Pierce, and all the staff for being kind and helpful to me in every way. I also want to thank you, my fellow delegates, for all your work, your interest, and your trust in allowing me to be your president.

"In my contact with other state associations, it has become very clear that our Association, the Medical Association of Georgia, is one of the very best in the country. We are fortunate to have as our incoming president, Dr. Joseph P. Bailey. Dr. Bailey is a man of rigorous intellect and strong will, truly a man

for all seasons.

"In closing, let me say that being MAG President has been a challenge, and as I leave the presidency, things look a lot different than when I was starting out as President."

### Installation of New Officers

As the last official duty as President of the Medical Association of Georgia, Jack F. Menendez, M.D. of Macon, installed the new officers of the Medical Association of Georgia.

Dr. Menendez passed the President's Gavel to Joseph P. Bailey, Jr., M.D. of Augusta, which symbolizes the transfer of leadership of the Medical Association of Georgia.

### President's Address

Joseph P. Bailey, Jr., M.D., 1988-89 President of the Medical Association of Georgia, made the following remarks in his initial address to the delegates:

"To be a physician and have you as my associates and friends and now to have you elect me as President of the best medical association in this nation — yours and mine — The Medical Association of Georgia! What more could a person ask for?



*Jack and Connie Menendez. Mrs. Menendez was instrumental in planning the Installation Ceremony and worked on behalf of MAG along with her husband during his presidency.*



## Final General Session-Installation Ceremony

"Here in Savannah, I am reminded of General Robert Edward Lee — born on January 19, 1807, and dying October 12, 1870 — leaving an indelible and positive mark on mankind. He served on Cockspur Island at the mouth of the Savannah River from August of 1829 until May of 1831, where as a Brevet Second Lieutenant in the Engineers he played a vital role in the construction of Fort Pulaski. During the war, he was honored when Herman L. Schreiner here in Savannah composed General Lee's Grand March.

"But the thing that tonight is so poignant in my thoughts and has so much relevance to our organization and our role as physicians was Lee's comment to his son — 'Duty is the sublimest word in our language. Do your duty in all things. You cannot do more. You should never wish to do less.'

"My other thought of this great man is the obvious chasm of failure crossed by all who fail to recognize the value of unity. For us, unity and duty pursued as positive honorable attributes will serve medicine well.

"The Practice of Medicine, The Medical Profession, Patients, Patient Care, Professionalism, Education, Research, Medical Ethics. These are all words that have specific meaning to each of us, and yet, their meaning to those outside of medicine may be different. The physician is a special person in our society that functions to serve; to be the servant of the patient. His or her care is provided with intelligence, hard work, and compassion. Also, it is provided with an all encompassing concern for the patient which extends far beyond the single issue of a particular problem or presentation. As has been emphasized in this past year by stressing a healthy life style, it is important for the public to know that our concerns extend beyond the issue of sickness.

"Our education in both its specific and global character lends the very special quality to each of us

that is what we desire as individuals when we seek medical care. This care is born of a tradition based on performance, fact and sacrifice — not on one of veiled hope. We must not lose sight of what we are, what we have accomplished, and what the future will be for us and our patients.

"Examine carefully what has happened to such problems as: Infections as exemplified by small pox, poliomyelitis, tuberculosis, and syphilis; surgical intervention with major advances being noted in the arena of cardiovascular disease, transplantation, plastic repair, joint replacement, arthro-



(L to R): Drs. Jack F. Menendez, James A. Kaufmann, and Joseph P. Bailey.

scopic surgery and cataract surgery; the management of gout; the treatment of hypertension; pediatric care; anesthesiology; renal dialysis; plasmapheresis; blood and blood product administration; metabolic and endocrine diseases; obstetrics and gynecology, and cardiopulmonary resuscitation. Also, diagnostic techniques have been a major contribution to our advances as noted by magnetic resonance imaging, computerized axial tomography, nuclear medicine, endoscopy, dye contrast studies, and general pathology.

"These are all very positive considerations but, obviously, they are associated with other definitive and yet unresolved problems such as: cancer, diabetes mellitus, vascular diseases, developmental abnormalities, viral infections, musculoskeletal disease, and immunological disorders.

"We have made great progress and there is much yet to come. Let us join together to bring our profession to even greater levels of satisfaction for us and our patients. To do this, we need to come together bound by continued belief in our-



## Final General Session-Installation Ceremony



*As the last official duty as President of the MAG, Dr. Menendez installed the new officers of the Association.*



*Dr. Menendez (right) welcomes newly installed MAG President Joseph P. Bailey, M.D., of Augusta.*



## Final General Session-Installation Ceremony



*The audience was well entertained at the Installation Ceremony.*



*Dr. Joseph P. Bailey addresses the audience in his new position as President of the Medical Association of Georgia. "You need your help!", he said. "This is to indicate that physicians must join in the mutual pursuit of the betterment of the profession and its provision of care."*

selves and our professional abilities. *You need your help!* This is to indicate that physicians must join in the mutual pursuit of the betterment of the profession and its provision of care. We must, in trying circumstance, resort to belief in the fundamental and altruistic character of the physician to function for the betterment of the patient. This girds us with armor of uncommon protective ability and yet, it also makes us vulnerable to any chinks in this armor which for certain will be found by our detractors. But to be human is to be vulnerable. We will make errors in judgment. However, to recognize and have compassion for *all*, including ourselves, is mandatory, striving to effect positive change for everyone.

"I am saying that each of you is special, you and your family, and this special individual character that you represent is vital to society. We must convey this to the public and specifically to those in government that may be persuaded otherwise. To accomplish this we must bind ourselves together through the Medical Association of Georgia at the state level and the American



Medical Association at the national level to have an effective voice and ability to govern the fate of medicine. Although a great task, I intend in my small way to work to this end. I implore you to join in the effort and will unhesitatingly remind you of this need at every opportunity. You have bestowed upon me, my family and my friends, a great honor and awesome but welcome responsibility. The success of the Medical Association of Georgia and its Auxiliary this year will not be mine, but ours.

"This day I pledge to you my efforts for the betterment of our plight and that of our patients. To you, your families, and those you represent, may only the good and positive things of this life be your burden, and I pray for God's blessing on each and everyone of us in the endeavors of this year and those to come."

#### **Adjournment**

There being no further business, the Speaker adjourned the 1988 House of Delegates at 7:30 p.m.



*Following the Installation Ceremony was the Annual President's Reception and Dance. Shown here are Dr. Roy Vandiver and Maureen Vandiver, Immediate Past President of the Auxiliary to the MAG.*



*Finally relaxing at the reception are (L to R) Connie Menendez (Mrs. Jack); Mrs. Harrison Rogers, Jr.; Dr. Carson "Bucky" Burgstiner; and Jackie Burgstiner.*



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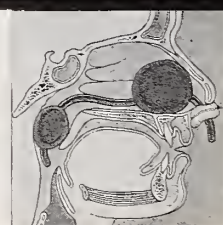
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Sorter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. *N Engl J Med* 1976;294:687-90.

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**Indications and Usage:** Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

Axid is indicated for maintenance therapy for duodenal ulcer patients, at a reduced dosage of 150 mg b.i.d. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

**Contraindication:** Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H<sub>2</sub>-receptor antagonists.

**Precautions:** *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

**Laboratory Tests**—False-positive tests for urobilinogen with Multistix<sup>®</sup> may occur during therapy with nizatidine.

**Drug Interactions**—No interactions have been observed between Axid and theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility**—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice; although hyperplastic nodules of the liver were increased in the high dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement

compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Teratogenic Effects—Pregnancy Category C**—Oral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers**—Nizatidine is secreted and concentrated in the milk of lactating rats. Pups reared by treated lactating rats had depressed growth rates. Although no studies have been conducted in lactating women, nizatidine is assumed to be secreted in human milk, and caution should be exercised when nizatidine is administered to nursing mothers.

**Pediatric Use**—Safety and effectiveness in children have not been established.

**Use in Elderly Patients**—Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to

determine whether these were caused by nizatidine.

**Hepatic**—Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

**Cardiovascular**—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

**Endocrine**—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

**Hematologic**—Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H<sub>2</sub>-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs.

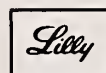
**Integumental**—Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients. Rash and exfoliative dermatitis were also reported.

**Other**—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

**Overdosage:** There is little clinical experience with overdosage of Axid in humans. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LD<sub>50</sub> values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively. PV 2091 AMP [041288]

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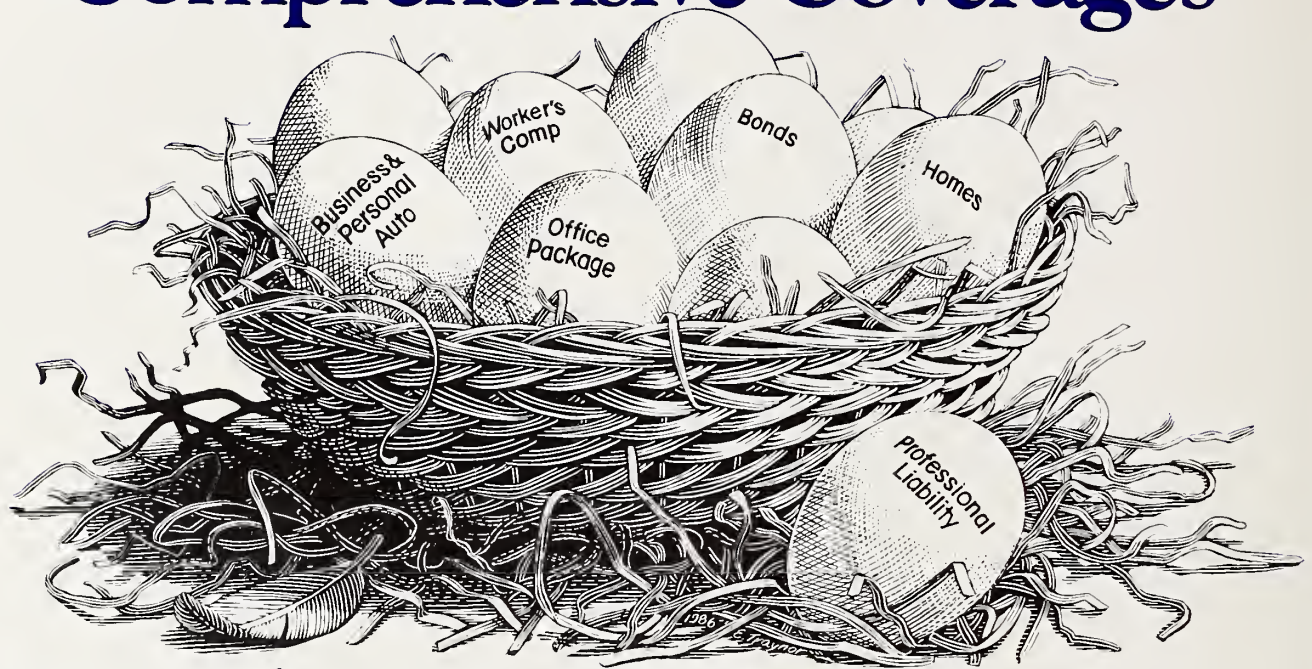
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*Nuclear Aftermath — Implications for Atlanta*



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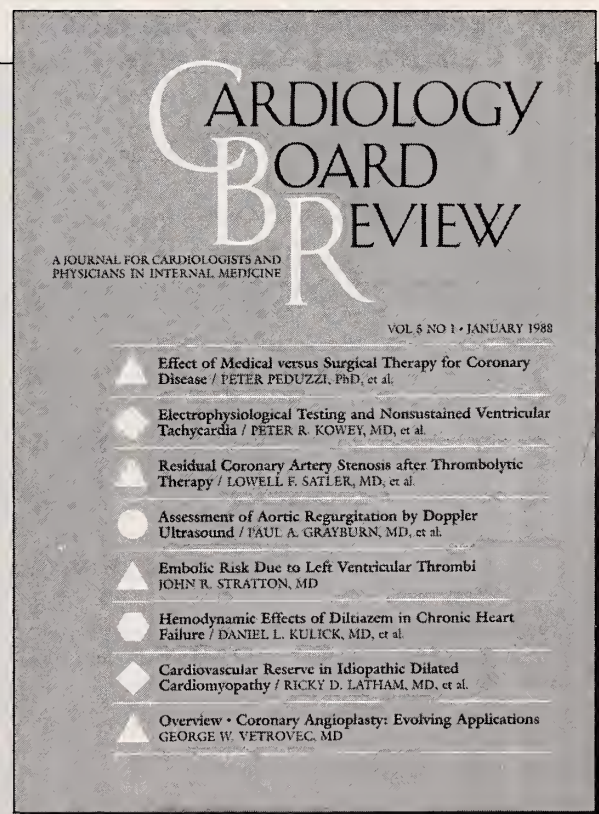
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\*Journals reviewed include: *Circulation*, *American Heart Journal*, *Journal of the American College of Cardiology*, *British Heart Journal*, *Chest*, *The American Journal of Cardiology*, *The New England Journal of Medicine*, *Annals of Internal Medicine*, *American Journal of Medicine*, and *The Journal of the American Medical Association*.



# The Future Effect Of AIDS On Your Insurance Plans

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40-49	\$ 93.00	\$260.00	40-44	\$ 49.00	\$127.00
50-59	\$148.00	\$370.00	45-49	\$ 59.00	\$142.00
60-64	\$211.00	\$498.00	50-54	\$ 70.00	\$155.00
			55-59	\$ 84.00	\$169.00
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**COVER**

"No Place To Hide" is the title of the cover painting by Atlanta artist, Cathy Logan. See page 535 for a discussion of this artist's work in relation to our feature articles on nuclear war on pages 546, 551, and 557.



# MR UPDATE

## MRI Advances the Detection of AVM's

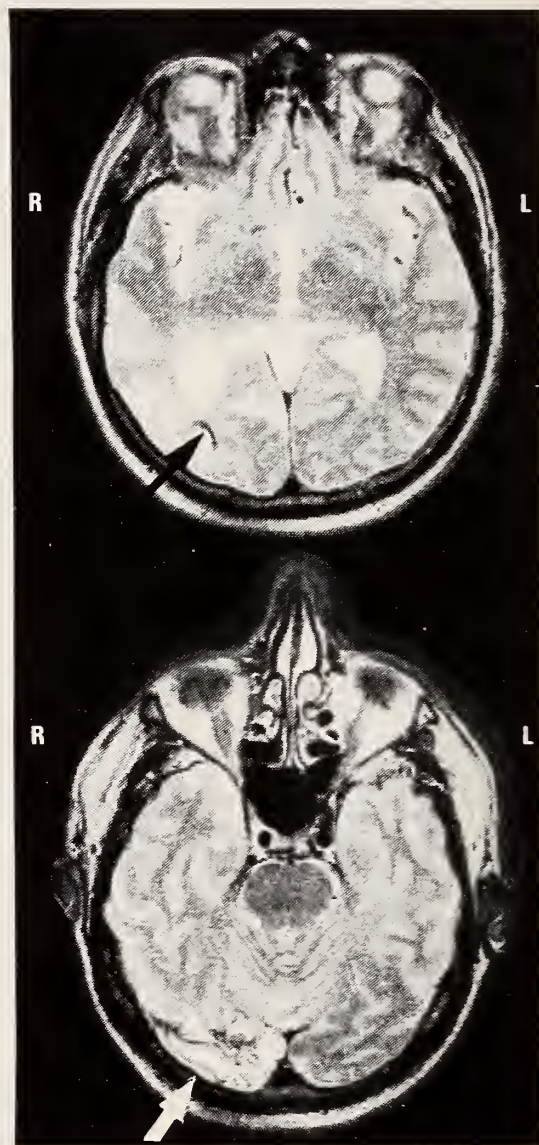
### BRAIN EXAMINATION

**HISTORY:** A 52 year old man had two small right occipital hemorrhages, 18 months apart. After resolution, negative studies included two cerebral arteriograms and contrast CT scans.

**SCAN:** Several dark curvilinear structures, evidence of the flow void phenomenon, indicate abnormal vasculature in the right occipital lobe. Associated high signal intensity of adjacent white matter is compatible with edema, hemorrhage, or gliosis. Together these findings are consistent with occult arteriovenous malformation (AVM).

**MRI HIGHLIGHTS:** MRI is highly sensitive for AVM's which are otherwise occult by arteriography or CT scanning. These may be found in patients with spontaneous hemorrhage, seizure disorder, or other clinical presentations. In addition, the sensitivity of MRI for intracranial hemorrhage is being increased through the use of new partial flip imaging techniques. Refinements in signal processing, surface coils, and other techniques continue to expand the clinical indications of MRI. Because of its sensitivity, safety, and patient comfort, MRI is the screening technique of choice for most CNS abnormalities.

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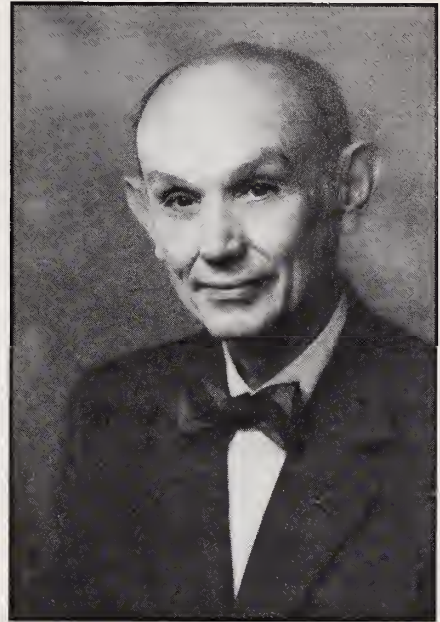
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*Joseph P. Bailey, Jr., M.D.*

I recently had the privilege of attending the Annual Session of the North Carolina Medical Society and meeting many old friends and making some new ones. The realization of the common bond created by the practice of medicine was immediately apparent. It was expressed in the ease of association, common pride in achievement, and recognition of mutual problems that confront the House of Medicine. There was an obvious frustration expressed as to the solutions that are so elusive. I strongly suspect that our problems are no greater, however, than those of our predecessors. Yet, they are our problems and those which must be dealt with now.

The high principles that have governed the evolution of medicine are still applicable. We must obviously adapt to an ever-changing society, but if our profession was founded on sound principle, and of this I am certain, then we should continue to apply this principle in relation to our patients and to each other. This premise also has to transcend our relation with those in government at all levels. Our society has moved toward legalistic activity which too often seems unable to view the human condition save in terms of perceived absolute finality. For us the biological unknowns remain, coupled with the expressed fear they generate for man. Let us all realize the continued existence of these problems and pursue the answers while demonstrating adherence to the high ethics and principles of our profession. We must show disdain for the lesser and unacceptable approach that would be fostered on us directed at creating a trade and destroying a profession.

*Joseph P. Bailey, Jr.*



## Catastrophic-Illness Bill Approved

**H**ouse and Senate negotiators last May unanimously approved legislation to protect the nation's 32 million elderly people from catastrophic hospital, physician, and outpatient-drug costs. The legislation, which has a projected \$31 billion, 5-year price tag, is the most sweeping expansion of Medicare since the program began in 1965.

Some 6.5 million beneficiaries are expected to benefit from the outpatient-drug provisions, which would take effect in 1991, and about 2 million would benefit from the \$1440 cap on Part B out-of-pocket expenses. Only 125,000 beneficiaries would be protected under the hospital changes, and the bill's impact on hospitals is expected to be minimal.

The plan calls for Medicare Part A hospital benefits and those for care in skilled nursing facilities or hospices to begin in 1989. Under the bill, Medicare would pay for unlimited hospital care after beneficiaries pay an annual deductible, estimated by the Congressional Budget Office to be \$564 in 1989. Medicare Part B benefits, including limitations on beneficiaries out-of-pocket expenses and 80 hours of respite care annually for elderly people exceeding the drug or Part B thresholds, would begin in 1990. The AHA has applauded this bill.

## Changes in Physician-Pay Reform Predicted

**H**CFR Administrator William L. Roper, M.D., predicted incremental rather than radical physician-payment reforms in the short term. At a May 24 hearing before the House Ways and Means Committee's health subcommittee, Roper called for utilization review, physician-fee limits, and payment reductions for

overpriced procedures to stem Medicare Part B costs, which have been rising more than 15% annually in the past few years.

"The federal government does not have an effective mechanism to constrain the rapid growth in physician spending in the near term," Roper said. He ruled out implementation of a physician DRG system. "Monitoring 11 million admissions from 7,000 hospitals for 475 DRGs pales in comparison to reviewing 350 million bills from 500,000 physicians for 7,000 different procedure codes," he said.

## Physicians Can Sue in Peer Reviews

**I**n a widely watched case, the U.S. Supreme Court ruled last May that physicians do not have absolute immunity from antitrust lawsuits that may arise from their actions as members of peer review committees.

The case was brought by Timothy Patrick, M.D., a surgeon who resigned from a hospital in Astoria, OR, after a peer review committee moved to terminate his staff privileges. A jury found that the defendants had conspired against Patrick and awarded him \$650,000 in damages, which was tripled under the Sherman Antitrust Act to \$1.9 million, plus attorney's fees.

"It doesn't mean peer review will have no protection, said the senior for the AHA. "The decision in no way undermines the immunities given for good-faith peer review under the Health Care Quality Improvement Act (of 1986)."

"We disagree with the outcome (of the case) and think it could have a chilling effect on peer review," said Kirk Johnson, the AMA's general counsel. He expressed concern that physicians may participate in peer review with less vigor.

## Government Eyes Lab Performance

**T**he Health Care Financing Administration is taking a hard look at clinical laboratories with the intention of updating and improving clinical lab regulations and also to set up uniformity among hospital-based and independent labs.

In recently drafted regulations, HCFA proposes to change personnel standards to focus on accuracy rather than on educational qualifications. In addition, HCFA wants to require that hospital labs have supervisors on the premises to monitor routine testing, mandate proficiency testing programs for Medicare-approved lab specialties, and update internal quality control methods.

The concern over lab performance has been spurred by reports of inaccurate Pap and cholesterol tests. However, the American Hospital Association is quick to point out that the main source of the inaccurate tests is in independent labs and not hospital labs. Independent labs, says the AHA, often follow inadequate quality control standards.

## Government Reviews Hospitals' Tax Status

**T**he House Ways and Means Committee's oversight panel has tentatively approved a plan to change the tax-exempt criteria for not-for-profit hospitals, and the hospital industry fears the plan may eliminate the exemption for hospitals that operate taxable businesses.

As part of its plan, the panel has recommended repeal of the current rule that exempts hospital services provided for the benefit of employees, patients, and students. But the group favors keeping exemptions for donated property and proceeds from fund-raising events.





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# Quiet Thoughts

**W**e would like to make "Quiet Thoughts" a regular or, depending upon our readers, an irregular department of the *Journal*, featuring short articles about experiences with medical practice, the family, politics, hospitals — whatever touches on the feeling side of being human. Our parameters are flexible, as we want to encourage you to submit material, in the same vein as *JAMA's* "A Piece of My Mind." You are invited to contribute to this department, as is your wife, your office staff, your minister, or whoever you may know who has something brief and interesting to say about the human condition.

---





## ALLAN J. HAMILTON, M.D.

Neurosurgical Resident and Research Fellow,  
Massachusetts General Hospital, Boston, Massachusetts.  
Captain, U.S. Army Reserve.

**EDUCATION** Ithaca College, B.A. (Magna Cum Laude);  
Hamilton College (Pre-med); Harvard Medical School.

**RESIDENCY** General Surgical Internship. Neurosurgical  
Residency, Massachusetts General Hospital.

**CONTINUING EDUCATION** Neurology and Neuro-  
surgery Research Fellowship Training, National Institutes  
of Health.

**OUTSTANDING ACHIEVEMENTS** Olsen Memorial  
Fellowship, National Masonic Medical Research Foundation;  
Albert Schweitzer Fellowship, International Albert Schweitzer  
Foundation; Harvard Medical School Cabot Prize for Best  
Senior Thesis; recently published article, "Who Shall Live  
and Who Shall Die" in Newsweek Magazine.



Soldier being examined for effects of high-altitude cerebral edema.

“The work I’m doing in the Army Reserve fits perfectly with my academic research interests in civilian life. The Army is very concerned with the effects of high-altitude cerebral edema, which is a mirror model of cerebral hypoxia, something I deal with every day in our neurosurgical intensive care unit. I couldn’t ask for a smoother transition. And that’s true for a lot of Reserve physicians. All we really do is change our clothes, not our mindset.

“Some of the projects the Army is undertaking are on the cutting edge of research. For example, I’m currently involved in developing for the Army a prototype of a non-invasive intracranial pressure-monitoring device that we hope will allow us to measure pressure changes as the brain swells—without drilling holes in the skull. If we can get our design to work, such a device could revolutionize high-altitude medicine as well as civilian neurosurgical care.

“The quality of medicine and the caliber of people I’ve been associated with in the Army Reserve are, without question, equal to civilian hospitals. In fact, I’m giving serious consideration to applying for an active duty academic position in Army Medicine when my residency ends at Massachusetts General. //

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**Brief Summary.** Consult the package insert for prescribing information.

**Indications and Usage:** Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

Axid is indicated for maintenance therapy for duodenal ulcer patients, at a reduced dosage of 150 mg h.s. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

**Contraindication:** Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H<sub>2</sub>-receptor antagonists.

**Precautions:** *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

**Laboratory Tests**—False-positive tests for urobilinogen with Multistix<sup>®</sup> may occur during therapy with nizatidine.

**Drug Interactions**—No interactions have been observed between Axid and theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility**—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement

compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Teratogenic Effects**—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers**—Nizatidine is secreted and concentrated in the milk of lactating rats. Pups reared by treated lactating rats had depressed growth rates. Although no studies have been conducted in lactating women, nizatidine is assumed to be secreted in human milk, and caution should be exercised when nizatidine is administered to nursing mothers.

**Pediatric Use**—Safety and effectiveness in children have not been established. **Use in Elderly Patients**—Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to

determine whether these were caused by nizatidine.

**Hepatic**—Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

**Cardiovascular**—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

**Endocrine**—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

**Hematologic**—Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H<sub>2</sub>-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs.

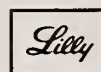
**Integumental**—Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients. Rash and exfoliative dermatitis were also reported.

**Other**—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

**Overdosage:** There is little clinical experience with overdosage of Axid in humans. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LD<sub>50</sub> values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively. PV 2091 AMP [041288]

Axid<sup>®</sup> (nizatidine, Lilly)



**Eli Lilly and Company**  
Indianapolis, Indiana  
46285

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Axid<sup>®</sup> (nizatidine, Lilly)



## About the Cover Artist



### Cathy Logan

**F**EATURED on this month's cover is an oil painting, "No Place To Hide," by Atlanta artist, Cathy Logan. The slightly unreal but complimentary colors in this painting, its jigsaw puzzle lake and house in the sky, space divided into a grid, and a mushroom the size of a tree are visual metaphors for our paradoxically "safe" yet imminently threatened life in the Nuclear Age. If a weapon can be named "Peace-keeper," why not color a bomber in a beautiful bright red? (Is an instrument of death more acceptable if it has a fine name or color?) For more than 40 years, we have been encouraged to believe nuclear weapons exist for our protection from nuclear weapons — but they are like an umbrella as fragile as a mushroom which breaks apart at the slightest touch.

In "No Place To Hide," the child has seen the bomber and fled; only the empty swing returns to the picture plane. An ambiguous scene exists at the bottom left of the painting. Is the reclining woman in another world observing the beau-

ties of nature, unaware of the danger from above? Perhaps the painting outside her sphere is a nightmare of her thoughts. Just as tens of thousands of nuclear weapons are hidden in silos, submarines, bombers, and moved about by train, so the shape of a puzzle piece is likewise hidden in this landscape and also symbolizes the ultimate contemporary puzzle — that of reversing the Arms Race.

**S**INCE 1982, Ms. Logan has created images of the psychic landscape we inhabit as a result of living in the Nuclear Age. The psychologic burden created by numbing ourselves to the responsibility of living at this historic juncture offers a fascinating and challenging subject for the artist. Ms. Logan's paintings combine the narrative form of the human in landscape with shallow modernistic space and composition, and fantastic elements. The viewer can thus realize these are pictures of thoughts, ideas, and concerns,

rather than actual events. Harmony and sensuousness of color draw the viewer in and make the content accessible. Ideally, viewers will allow themselves to explore their feelings about living with nuclear weapons.

Ms. Logan received her B.F.A. in 1974 from the Kansas City Art Institute in Kansas City, Missouri, and attended graduate school at the Tyler School of Art in Philadelphia. Most of Ms. Logan's work is done in oil on canvas; some is acrylic, pastel, or watercolor. She welcomes commissions.

Recent exhibits include 12 paintings in the Bathhouse at the 1987 Arts Festival of Atlanta; "Weaving Women's Colors: A Decade of Empowerment" at Spelman College in Atlanta; and the 1986 Irene Leache Memorial Exhibition at the Chrysler Museum in Norfolk, Virginia. Ms. Logan has had four one-person shows, has exhibited in eight states and in Nairobi, Kenya, and has paintings in many private collections. Her work can be seen at the Highland Gallery, 1164 N. Highland Ave., in Atlanta. ■



## On Death and Euthanasia

*"Everybody has to die sometime. That's life."*

ARCHIE BUNKER

*"The way I figure it, if you're too afraid to die, then you're too afraid to live."*

JOHN WAYNE

IT SEEMS such an easy, such an effortless, thing to do — dying, that is. One hardly has to lift a hand to accomplish it. On occasion, simply to turn over in bed will do it. We all know that it has to come, sooner for some, later for others. It seems so unavoidable, so devious in the methodical manner in which it seeks us out, so effortless and unavoidable. The fragility of our lives seems ever to surround us as we pass daily through the "valley of the shadow of death."

Philosophers have taught us how to look at death, or best to say, have taught us how they perceive the function and perhaps instruct us as to how we must, should, or might consider regarding it.

Montaigne knew about death. Born Michel de Montaigne in 1533 at Perigord in France, he retired to his home in 1571 to write his memoirs, the "Essays" to which his reputation must be attributed. He became the mayor of Bordeaux in 1580 and died at the Chateau de Montaigne in 1592. Those Essays, in the words

of Montaigne, were simply a looking at himself. In the course of doing that, he dealt with the many issues that even today we find filling the mind of modern man. At one place in those essays, he makes the following remarks concerning death:

*"Tullius Marcellinus, a young Roman, wishing to anticipate the hour of his destiny, in order to rid himself of a disease which tormented him more than he was willing to endure, although the physicians promised him a certain, if not a very rapid, cure, summoned his friends to deliberate about this. Some, says Seneca, gave him the advice which, from cowardice, they themselves would have taken; the others, to please him, that which they thought would be most agreeable to him. But a Stoic spoke thus to him: 'Do not exert yourself, Marcellinus, as if you were deliberating about something of importance; it is no great matter to live — your servants and the beasts live; but it is a great matter to die worthily, wisely, and firmly. Think how long you have been doing the same thing: eating, drinking, sleeping; drinking, sleeping, and eating. We revolve incessantly in this circle; not only disagreeable and unbearable circumstances, but the mere satiety of living, make us long for death.'*

*Marcellinus had need, not of a man to advise him, but of a man to help him. His servants were afraid to meddle in the affair; but this philosopher made them understand that those of a man's household are suspected only when there is some doubt whether the master's death has been voluntary; otherwise, that it would be as bad an example to prevent him from killing himself as to kill him, because,*

**H**e who against a man's will preserves his life does the same thing as if he killed him.

... For all else, there was no need either of iron or blood; he undertook to depart from this life; not to flee from it; not to escape death, but to experience it. And, to give himself time to deal with it, he refused all nourishment; and on the third day after, having had himself bathed in warm water, he failed little by little, and not without some pleasure, as he said. In truth, they who have had these faintnesses that come from weakness say that they feel no suffering in them, indeed, rather some pleasure, as of a passage into sleep and rest."

But that was a world of seductive contemplation. We must live in the world of today, in what Allen Watts called, "The Eternal Now." We must deal with



not only death but also death with intent. Surely we cannot ignore the matter. We must not run away from it as we on occasion have from other issues. Nor must we, as unproductively, take a stand so rigid and inflexible that we leave no room for compromise and so abandon the field of debate and decision making to those less qualified with knowledge but better fortified with decision making power to draw the guidelines whereby we must perform.

**I**n a moment of carefully calculated decision making within the recent past, an Editorial Board representing the journal of 45% of American physicians printed a short article by a resident physician describing the facilitated death of one of his patients. From the gently ignited issue burst forth a conflagration seeking out the most obscure recesses of the lay and professional world. Should he have done it? Would my pastor, my father, my doctor have approved of it? Would I have done it? "Aye," as Shakespeare's Hamlet would have said, "there's the rub."

Well, we have all done it, either in a fantasy, in quiet contemplation, or as the resident, *really* done it. Our sadness over the agony and the impending

death of a beautiful person — beauty as physical, intellectual, emotional — has led us to give at least some passing thought to just what the rightful place of the facilitated death, euthanasia, should be.

Of course, it is unacceptable, the taking of human life. We are trained to maintain it as long as possible and this as long as reasonable or unreasonable. Dare we then to throw our thinking into the philosophical cauldron and ask the Socratic question, "Is there need to draw the guidelines whereby the thoughtful and compassionate physician might abet the passing from life to death?" Evermore difficult becomes the judicious balancing of the autonomy of the individual, their right to control their own destiny, and in particular their own death, with the professionally trained and nurtured beneficence of the physician to lend to the sick and injured the appropriate compassion and concern. We have suffered with the dilemma for ages. We have walked the thin line of propriety, played God, if you will, and find ourselves today ever closer to that awesome point where we consciously tinker with such creative process as vitro fertilization, abortion, genetic engineering, organ transplantation and the like. We appear more as final arbiters, as determiners, of life and death than ever before.

***“The time has arrived when the facilitators of the beginning of life, the caretakers of health and life, must look to their rightful place in the unavoidable function of assisting with the proper and societally approved manner of ending that life.”***

Dare we ask ourselves to look at the rules governing the end of our lives? We have danced around the issue, taken refuge in theological and philosophical conundrums, about as long as reason will allow. The time has arrived when the facilitators of the beginning of life, the caretakers of health and life, must look to their rightful place in the unavoidable function of assisting with the proper and societally approved manner of ending that life.

CRU



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# CALENDAR

## AUGUST

8-12 — *Destin, FL: Summer Imaging and Interventional Techniques VI.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

11-14 — *Amelia Island: Georgia Psychiatric Summer Meeting.* Category 1 credit. Contact James M. Moffett, MAG, 938 Peachtree St., Atlanta 30309. PH: 404/876-7535 or 800/282-0224.

15-19 — *Atlanta: A Comprehensive Board Review in Internal Medicine.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

26-28 — *Kiawah Island, SC: Georgia Society of Anesthesiologists/South Carolina Society of Anesthesiologists Meeting.* Contact William Hammonds, M.D., 1365 Clifton Rd., Atlanta 30322. PH: 404/321-0111.

## SEPTEMBER

2-4 — *Callaway Gardens: Georgia Society of Internal Medicine/Georgia Chapter, American College of Physicians* Category 1 credit. Contact James M. Moffett, 938 Peachtree St., Atlanta 30309. PH: 404/867-7535 or 800/282-0224.

9 — *Atlanta: Hepatic Surgery.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

15-17 — *Sea Island: Georgia Surgical Society.* Category 1 credit. Contact William C. McGarity, M.D., 1365 Clifton Rd.,

Atlanta 30322. PH: 404/321-0111.

19-20 — *Atlanta: Second Annual Menopause Conference.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

14-16 — *Atlanta: Advances in the Diagnosis and Treatment of Cardiovascular Diseases.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

14-16 — *Savannah: Neonatology — The Sick Newborn.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

22-24 — *Hilton Head Island, SC: Frontiers in Nutrition.* Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

23-24 — *Atlanta: The Clinical Management of Sickle Cell Disease.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

23-24 — *Atlanta: Introduction Into Percutaneous Transluminal Angioplasty VII.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

26-29 — *Atlanta: Advanced Demonstrations in Percutaneous Transluminal Angioplasty XX.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

26-30 — *Atlanta: Modern Methods of Diagnosing and*

*Treating Diabetes Mellitus and Its Complications.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

27-28 — *Atlanta: Public Health Service Policy on Humane Care and Use of Laboratory Animals.* Category 1 credit. Contact Office of CME, Emory

28-29 — *Atlanta: Georgia Chapter of the American Academy of Pediatrics Fall Meeting.* Contact Executive Secretary William C. Mankin, 4059 Land O'Lakes Dr., Atlanta 30342.

29-30 — *Atlanta: Stress and the Heart: Risks and Recovery.* Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

30 — *Atlanta: Recent Advances in Clinical Oncology,* Category 1 credit. Contact David Gordon, M.D., 1365 Clifton Rd., Atlanta 30322. PH: 404/727-6761.

## OCTOBER

5 — *Atlanta: Joseph S. Skobba Symposium (Psychiatry).* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

6-9 — *Sea Island: Georgia Orthopaedic Society.* Category 1 credit. Contact David F. Apple, Jr., M.D., 1938 Peachtree Rd., Ste. 710, Atlanta 30309. PH: 404/352-2234.

10-14 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.



## NEW MEMBERS

- Alvisio, Frank V., Student — MAA — 1461-D Willow Lake Dr., Atlanta 30329
- Amos, Joseph D., Student — MAA — 720 Westview Dr., Atlanta 30310
- Antolic, Mladen, Rehabilitation Med. — MAA — 11685 Alpharetta Hwy., Ste. 155, Roswell 30076
- Bakin, Dawn R., Student — MAA — 1022 Cedar Forest Ct., Stone Mountain 30083
- Blackburne, Rose E., Student — MAA — 720 Westview Dr., S.W., Atlanta 30310
- Blake, Bryan D., Student — MAA — 170 Chappel Rd., N.W., Atlanta 30314
- Bland, James R., III, Resident — Richmond — 234 E. Vineland, Augusta 30904
- Boone, Daniel H., Internal Medicine — Richmond — 3623 J. Dewey Gray Cir., Augusta 30907
- Brackett, Michael L., Family Practice — Troup — 303 Smith Street, LaGrange 30240
- Brown, Robert M., General Surgery — MAA — 4282 Spring House Lane, Norcross 30092
- Buckner, Janet M., Student — MAA — 1418-A Druid Valley Dr., Atlanta 30329
- Charles, Deborah J., Diagnostic Radiology — Cherokee-Pickens — 518 Cherokee Mills Dr., Woodstock 30188
- Clarke, Dane E., Student — MAA — 2909 Campbellton Rd., Apt. 11-H, Atlanta 30311
- Covington, Nancy M., Pathology — Floyd-Polk-Chattooga — 309 E. Third Ave., Rome 30161
- Desai, Kishor D., General Psychiatry — Muscogee — 100 Center St., Ste. 501, Professional Tower, Columbus 30901
- d'Heurle, David, Ophthalmology — MAA — 2004 Peachtree Rd., Atlanta 30367
- Dix, Barry R., Cardiology/Internal Med. — MAA — 5667 Peachtree Dunwoody Rd., Ste. 385, Atlanta 30342
- Felz, Michael W., Family Practice — Richmond — 1708 Sandalwood Dr., Augusta 30909
- Finan, Marian C., Dermatopathology — MAA — 1800 Phoenix Blvd., Ste. 210, Atlanta 30349
- Finley, Charles R., General Surgery — MAA — 1233 Oxford Rd., Atlanta 30306
- Flannery AnnMarie, Pediatric Neurosurgery — Richmond — Medical College of Georgia, Augusta 30912
- Foshee, William S., Pediatrics — Richmond — 422 Cambridge Way, Martinez, 30907
- Goldstein, Adam O., Family Practice — Richmond — 2409 Comanche Rd., Augusta 30904
- Grayson, John T., Internal Medicine — Spalding — 231 Graefe St., Griffin 30223
- Gropper, Gary R., Neurological Surgery — MAA — 315 Boulevard, Ste. 300, Atlanta 30312
- Hein, Douglas P., Orthopaedic Surgery — Wayne — 113 Colonial Way, Jesup 31545
- Hochgelerent, Eda L., Internal Med./Nephrology — MAA — 77 Collier Rd., Ste. 2050, Atlanta 30309
- Holcombe, John L., Family Practice — Cobb — 153 Watson Dr., Dallas 30132
- Holzberg, Mark J., Dermatology — MAA — 401 West Peachtree St., Ste. 1645, Atlanta 30307
- Hortenstine, Jay S., Urology — Richmond — Dept. of Urology, Medical College of Georgia, Augusta 20912
- Huggins, Sharon G., Student — MAA — 2025 Peachtree Rd., N.W., #444, Atlanta 30309
- Jarrell, Todd S., Urology — Richmond — Medical College of Georgia, Augusta 30912
- Johnson, Robert E., — Richmond — 301-A Old Plantation Rd., Martinez 30907
- Johnston, Edwin D., Jr., Anesthesiology — Floyd-Polk-Chattooga — 5 River Valley Ct., S.W., Rome 30161
- Jones, Garris T., Family Practice — Crawford W. Long — 1030 Woodlands Rd., Watkinsville 30677
- Jones, Mark M., Plastic Surgery — MAA — 424 Webster St., Palo Alto, CA 94301
- Jones, Mitchell T., Student — MAA — 1155 Lullwater Rd., Atlanta 30307
- Jose, James A., Pediatrics/Neonatology — MAA — Ste. C-509, 5675 Peachtree Dunwoody Rd., Atlanta 30342
- Lee, Richard Y., Radiology — DeKalb — 755 Commerce Dr., Ste. 205, Decatur 30033
- Lev, Jeffrey D., Internal Med./



Endocrinology — Hall — 660-1  
Lanier Park Dr., Gainesville  
30501

Longley, Jean V., Obstetrics/  
Gynecology — MAA — 1938  
Peachtree Rd., Ste. 306, Atlanta  
30309

Mardis, Marlah H., Student —  
MAA — 2025 Peachtree Rd.,  
N.E., Atlanta 30309

Marks, Stuart D., Ophthalmology  
— Hall — 1128 Vine St.,  
Gainesville 30505

Martin, John E. — Ogeechee River  
— 417 Northside Dr. East, Ste.  
400, Statesboro 30458

Moore, L. Doyle — Richmond —  
3028 Pine Needle Rd., Augusta  
30909

Newman, Stuart J.,  
Ophthalmology — MAA — Ste.  
845, 5675 Peachtree Dunwoody  
Rd., Atlanta 30342

Niren, Lawrence S.,  
Anesthesiology — MAA — 1984  
Peachtree Rd., Ste. 515, Atlanta  
30309

Palsgaard, Donald C., Emergency  
Med./Family Practice —  
Crawford W. Long, 2661 New  
High Shoals Rd., Bishop 30621

Pantazis, Cooley G., Pathology —  
Richmond — 1120-15th St.,  
Augusta 30912

Perrick, David, Allergy &  
Immunology — Richmond —  
Medical College of Georgia,  
Augusta 30912

Prince, Jefferson B. — MAA —  
777-5 Houston Mill Rd., Atlanta  
30329

Quispe, Guillermo, Colon &  
Rectal Surgery — Washington,  
4 Medical Arts, Sandersville  
31082

Rhodes, Robert A., III Diagnostic  
Radiology — Crawford W. Long  
— 130 Walton Creek Rd.,  
Athens 30607

Riley, Scott A., Anesthesiology —  
Richmond — 3118 Natalie Cir.,  
Augusta 30909

Salzberg, Bruce A.,  
Gastroenterology/Internal Med.  
— MAA — 3192 Howell Mill  
Rd., N.W., Ste. 113, Atlanta  
30327

Scott, James F., III,  
Anesthesiology — MAA — 1861  
Clairmont Rd., Decatur 30033

Sebel, Peter S., Anesthesiology —  
MAA — Dept. of  
Anesthesiology, 1365 Clifton  
Rd., Atlanta 30322

Smith, Paul D., Student — MAA  
— 2815 Royal Bluff, Decatur  
30030

Steed, Robert D., Endocrinology/  
Internal Med. — MAA — 3193  
Howell Mill Rd., Ste. 230,  
Atlanta 30327

Stiles, Richard G., Radiology —  
MAA — 1365 Clifton Rd., Dept.  
of Radiology, Atlanta 30322

Strother, Reginald — MAA — 318  
Fourth St., #2, Atlanta 30308

Stuart, Karen A., Obstetrics/  
Gynecology — Muscogee —  
2039 Tenth Ave., Columbus  
31907

Stybol, Toncred M., General  
Surgery/Surgical Oncology —  
MAA — 1396 North Crossing  
Dr., Atlanta 30329

Sykes, James E., Student — MAA  
— 720 Westview Dr., Atlanta  
30310

Tarilton, Rebecca S., Therapeutic  
Radiology — MAA — 1365  
Clifton Rd., Atlanta 30322

Taylor, Ronald B., Emergency  
Medicine — Richmond —  
Medical College of Georgia,  
Augusta 30912

Wallace, Brian C., Internal  
Medicine — MAA — 35 Collier  
Rd., Ste. 200, Atlanta 30309

Wille, Carl R., Ophthalmology —  
MAA — 2004 Peachtree Rd.,  
Atlanta 30309

Wynn, James J., General Surgery  
— Richmond — Dept. of  
Surgery, Medical College of  
Georgia, Augusta 30912

Yarbrough, John A., Internal Med./  
Allergy & Immunology —  
Richmond — Medical College  
of Georgia, Augusta 30912

Yilling, Frederick P.,  
Cardiothoracic Anesthesia —  
MAA — 4140 River Cliff Chase,  
Marietta 30067

## QUOTES

*Praise, like gold and diamonds,  
owes its value to its scarcity.*

SAMUEL JOHNSON

*There is a pleasure in the  
pathless woods; there is a rapture  
in the lonely shore, there is  
society, where naught intrudes, by  
the deep sea, and music in its  
roar.*

BYRON

*I know that unremitting attention  
to business is the price of success  
but I don't know what success is.*

CHARLES DUDLER WARNER

*Rich men die but banks are  
immortal.*

WENDELL PHILLIPS



## PERSONALS

### *Canton-Charlton CMS*

**William A. McLaughlin, M.D.**, has relocated his OB/GYN practice to Waycross and has joined the staff of Memorial Hospital. He was previously on staff at a hospital in St. Mary's.

### *Cobb CMS*

**Richard W. King, M.D.**, has joined the Parkway Medical Center Staff. Dr. King specializes in rehabilitation medicine. Dr. King received his medical degree from the Emory University School of Medicine. He completed two residencies — one at Georgia Baptist Medical center in Atlanta and the other at Emory University's Center of Rehabilitation Medicine.

### *Georgia Medical Society*

**R. W. Scarbrough Jr., M.D.**, has been inducted into the South Atlantic Association of Obstetricians and Gynecologists.

### *Medical Association of Atlanta*

**Bonnie L. Anderson, M.D.**, a Diplomate of the American Board of Radiology, joined the staff at Fannin Regional Hospital in Blue Ridge last April. Dr. Anderson received her medical degree from the University of Miami in 1982. She was formerly affiliated with Mercy Hospital, New Orleans, LA, and Doctors' Hospital of Jefferson, Metairie, LA.

Dr. Anderson has a special interest in obstetric-gynecologic ultrasound and mammography, particularly geared towards womens' health. In addition, she will become a member of the Fannin Regional Speakers Bureau, and available to present womens' health topics to local clubs and organizations, as well as other radiologic topics.



*Alfred J. Grindon, M.D., Director American Red Cross Blood Services/Atlanta Region, receives national Red Cross Award.*

### *Sumter CMS*

**A. Gatewood Dudley, M.D.**, has accepted a position on the faculty of Emory University School of Medicine and will take a leave of absence from his Americus practice at Gynecology Associates, effective July 1, 1988.

**Alfred J. Grindon, M.D.**, Director of Red Cross Blood Services/Atlanta Region, received the Charles R. Drew Award for his outstanding contributions to Red Cross Blood Services at the American National Red Cross annual convention held in Cincinnati, Ohio, in May. The award was presented in recognition of Dr. Grindon's exceptional personal leadership and dedication and for his work in areas of scientific, medical, and technical development that

have advanced the purposes of Red Cross Blood Services.

The Charles R. Drew Award was established in 1981 to preserve the memory of Dr. Charles Drew's contribution to Red Cross Blood Services. Drew, a leading authority on mass transfusion and procession methods, was the medical director in the early 1940s for a nationwide project for the procurement of plasma for the armed forces. This project was the forerunner of the present American Red Cross Blood Services.

*An investment in knowledge  
always pays the best interest.*  
BENJAMIN FRANKLIN



## VOLUNTEERS NEEDED

Emory Clinic is looking for Type II diabetic volunteers, 40 to 70 years old, for a 5-month drug study which will evaluate a new method to quantitate peripheral insulin sensitivity and insulin secretion. As part of the study, Glucotrol (glipizide) or placebo will be administered in addition to diet therapy. Participants should be free of major medical problems and never have been on insulin or Glucotrol therapy. Multiple visits to the clinic over a 5-month period will be required. All medications and support services for the study are free to the participants. Clinical information gathered will be shared with the referring physician. Call Dr. Suzanne Gebhart, M.D. at 321-0111 Ext. 4528 for more information.

## ERRATUM

The following *EDITORIAL COMMENT* was intended to introduce the article by Ms. Betty Castellani, "Malpractice: Is Competence or Caring in Question?", published in the April issue of the *Journal* and was inadvertently omitted. We include it here now to remind those of you who read Ms. Castellani's article of its thoughtful excellence and to pique perhaps the curiosity of those who may have missed it. For those in the latter category, call the *Journal* office for a copy if you cannot find your April issue.

*EDITORIAL COMMENT: On rare occasions, a matter of great importance, known and reiterated to all of us through the years, is said again in such a straight and meaningful manner that suddenly it becomes clear when previously, though we thought it to be understood, it remained wrapped*

*in a cloak of ordinariness obscuring the truth which it possessed. Such is the nature of the following article by the Associate Chaplain at DeKalb General Hospital. Read it carefully and thoughtfully. Reread it. All the symposia, all the legal admonitions, all the reading you might be able to do will not lend to you the protection from professional liability threats which these simple suggestions of Ms. Castellani will provide.*

## MEDICAL TERMINOLOGY FOR THE LAYMAN

Artery: The study of fine paintings.  
Barium: What you do when CPR fails.  
Cesarean Section: A district in Rome.  
Colic: A sheep dog.  
Coma: A punctuation mark.  
Congenital: Friendly.  
Dilate: To live longer.  
Fester: Quicker.  
G.I. Series: Baseball games between teams of soldiers.  
Grippe: A suitcase.  
Hangnail: A coat hook.  
Medical Staff: A doctor's cane.  
Minor operation: Coal digging.  
Morbidity: A higher offer.  
Nitrate: Lower than the day rate.  
Organic: Musical.  
Outpatient: A person who has fainted.  
Post-operative: A letter carrier.  
Protein: In favor of young people.  
Secretion: Hiding anything.  
Serology: Study of English knighthood.  
Tablet: A small table.  
Tumor: An extra pair.  
Urine: Opposite of you're out.  
Varicose veins: Veins which are very close together.

## QUOTES

*It is a wonderful advantage to a man in every pursuit or avocation, to secure an adviser in a sensible woman. In woman there is at once a subtle delicacy of tact and a plain soundness of judgment which are rarely found to an equal degree in man. A woman, if she be really your friend, will have a sensitive regard for your character, honor, repute. She will seldom counsel you to do a shabby thing, for a woman friend always desires to be proud of you.*

THE EARL OF LYTTON

*Slow down and enjoy life. It's not only the scenery you miss by going too fast — you also miss the sense of where you're going and why.*

EDDIE CANTOR

*Rumba is a dance where the front of you goes along nice and smooth like a Cadillac and the back of you makes like a Jeep.*

BOB HOPE

*The road of excess leads to the palace of wisdom.*

WILLIAM BLAKE

*Touch a thistle timidly, and it pricks you; grasp it boldly, and its spines crumble.*

WILLIAM S. HALSEY

*There was a time when a fool and his money were soon parted, but now it happens to everybody.*

ADLAI STEVENSON

*Nothing is more humiliating than to see idiots succeed in enterprises we have failed in.*

GUSTAVE FLAUBERT

*We are most of us very lonely in this world; you who have any who love you, cling to them and thank God.*

WILLIAM MAKEPEACE THACKERAY



## The Probability of False Positive Results in HIV Antibody Testing

**I**N ANY LABORATORY test there is always the possibility of false positive results, including biological false positive (BFP) results that are not due to human error. In some studies of BFP reactions to human immunodeficiency virus (HIV) antibody testing, it has been found that the individual has antibodies, not to the virus protein, but instead to the proteins of the T-lymphocytes that the virus is grown in to make the test reagents.

How often do false positive results occur? This question has no simple answer. Currently HIV antibody testing generally consists of a series of sequential tests. A positive result is not reported unless two enzyme immunoassays (EIA) are positive followed by a positive Western Blot (WB). The latter test detects antibodies to the individual major proteins that make up the AIDS virus. Although not perfect, the WB is the best test we have as yet and is the "gold standard" for a positive HIV result.

Pharmaceutic and chemical companies that manufacture the various kits containing the reagents for the EIA and WB are required by the Food and Drug Administration (FDA) to publish the results of extensive testing using known positive and negative blood samples before the kits can be licensed and sold to laboratories in the United States. These test results are reported in terms of *sensitivity* and *specificity*. The *sensitivity* of an HIV test is the probability a test will be positive when HIV infection is present and the *specificity* is the probability that the test will be negative when HIV infection is absent. The sensitivity and specificity of the various EIA and WB kits used in AIDS testing are relatively very good compared to other biological tests but may vary from laboratory to laboratory.

The false positive rates for HIV testing done in reference or research laboratories ("best case") and in the "average" laboratory par-

ticipating in the American College of Pathology proficiency testing program in 1987 can be used to illustrate the problem. Multiplying the EIA rates by the WB rates gives the *combined* false positive rate. In the "best case" laboratory the false positive rate can be 1.0% for EIA and 0.5% for the WB or 0.005% combined. That is, 5 results in 100,000 tests may be false positive. Whereas in the "average" laboratory with rates of 1.7% for EIA and 4.7% for WB, 0.0799% or 80 tests per 100,000 may be false positives. In reality, the false positive rates are lower because a number of reactive specimens are interpreted as indeterminate rather than positive. It is important to realize that:

1. using the same laboratory and assay, the number of false positive results per 100,000 tests will be basically the same in any population screened, BUT:
2. the probability of any individual positive result being a false pos-

**TABLE 1 — Comparison of the Probability of a False Positive HIV Antibody Test Result in a Reference Laboratory Versus an "Average" Laboratory in Two Populations:**  
**Population A — 100,000 Homosexual Men — Prevalence 30%**  
**Population B — 100,000 Women Blood Donors — Prevalence 0.01%**

	Reference Laboratory		"Average" Laboratory	
	Pop. A	Pop. B	Pop. A	Pop. B
Combine False Positive Rate	.005%	.005%	7.99%	7.99%
Number of False Positives in 100,000 Tests	5	5	80	80
Number of True Positives	30,000	10	30,000	10
Ratio of False to	5	5	80	80
Total	30,005	15	30,080	90
Probability of a Result Being False	.016%	33.3%	.265%	88.9%



itive increases dramatically as the number of true positives decrease in the population being screened.

Table 1 illustrates this mathematical phenomenon in two populations; one a very high prevalence population of 100,000 homosexual men and the other a very low risk population of 100,000 women blood donors. We estimate that in Georgia, based on anonymous public health clinic testing, the true prevalence of HIV infection in homosexual men is about 30% or 30,000 true positives per 100,000 tests. We estimate the true prevalence in women blood donors in Georgia to be about .01% or 10 infected women per 100,000 women donors. In both of these populations, there would be the same number of false positives depending on the combined false positive rate of the laboratory performing the tests. Adding the false positives to the true positives and then dividing by the total gives the probability of any individual result being false. The probability of an individual positive result being false is very low in homosexual men, but potentially very high (33.3-88.9%) in women blood donors.

**EDITORIAL NOTE:** Because an HIV infection has no effective treatment and appears to be nearly uniformly fatal, a positive HIV antibody result can be very harmful to the mislabeled individual. Physicians, when confronted by this situation can try to determine if the result is false by repeating the test and searching for signs of early infection, such as T-lymphocyte depletion. Special tests such as radio-immune precipitation (RIP) or viral cultures may be done. Unfortunately, even if these special tests are negative, they do not rule out latent HIV infection, since even in full-blown AIDS cases these tests can be negative.

Some of the Red Cross blood bank laboratories have achieved combined false positive rates with EIA and WB AIDS testing as low as 0.001% or 1/100,000. Their experience has been that women blood donors who test positive when clinically studied usually give a history of exposure to high risk groups and are probably true positives. Whenever individuals are being tested for HIV antibodies, the quality of the laboratory must be assured by frequent proficiency testing. We believe the DHR laboratory to have a very low false positive rate.

In the future, there probably will be improvements in the interpretation of WB assays, improvements in the assays themselves, and the development of new assays to further reduce the combined false positive rates of many laboratories.

(Prepared by Joe Wilbur, M.D., Medical Director, DHR AIDS Activities)



## *Security in the Nuclear Age*

*William H. Foege, M.D.*

***‘In one of the ironies of history, the insecurity fostered by nuclear weapons may have acted as a surrogate for such an alien force, and this may increase our future security.’***

**T**ODAY, MAY 30, 1988, as I write this is Memorial Day. We think with thanksgiving of those who invested their time, talents, and sometimes their lives to improve the security that is now so American and so comfortable as to be a given. Indeed, so comfortable that it would be altogether natural to extrapolate forward from our past experience and assume that our future security is also tied to military expenditures and unmatched firepower.

Three other considerations claim my attention today. One is the review of an article for publication on child survival in the world. The power of science and medicine is impressive. Global infant mortality rates have fallen from 127 per 1000 live births in 1960 to 72 per 1000 today. They will reach 55 by the end of the century. Who could have foreseen the rapidity of this change for developing countries at mid-century? Life expectancy at birth, which for the entire world's population was less than 50 in 1960, is now more than 60 and will reach 65 by the end of the century. It is increasing faster in Africa than in the United States at the moment, and while this is not

all due to physicians, the power of medicine has played a part.

The other two considerations in my mind today are watching the progress of President Reagan and General Secretary Gorbachev on the second day of the summit, and a review of the articles by Kaplan, Jones, and Biel; and Koplan and Jones elsewhere in this issue. These two articles personalize what is often a theoretical discussion by forcing us to consider the implications of a nuclear blast over Atlanta.

**I**s there any connection? The historian, Polybius, taught us two thousand years ago that "the world must be seen as an organic whole." Everything affects everything. A more recent historian, Will Durant, observed the effect of the attack on Pearl Harbor and how it immediately negated the most violent differences between Americans as they united to fight a common threat. Durant said the world must unite in a similar way, if "security" is to be achieved, but he saw no way this could logically happen unless we thought we were to be invaded by an alien force. In one of the ironies of history, the insecurity

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fostered by nuclear weapons may have acted as a surrogate for such an alien force, and this may increase our future security.

***‘The world will listen to physicians and sometimes even politicians listen to physicians. That gives us a power we must use wisely.’***

Physicians can be pleased with the role of our profession in this process. The International Physicians for the Prevention of Nuclear War (the international counterpart of Physicians for Social Responsibility) has, in very few years, educated many to the senselessness of a kill potential that is beyond comprehension. The cofounders, Drs. Lown and Chazov, briefed General Secretary Gorbachev, and many feel they were influential in his decision to place a moratorium on nuclear testing for 18 months. In the next 2 days, a signing ceremony is planned for the INF treaty. With the first small treaty, the world has taken a single step back from

the precipice. We can now rethink the nature of security and make sure that we don't cheapen the sacrifices of those who carry our debt (because of their past military actions) by blindly assuming that future security can only be purchased through a quartermaster.

**J**ust as physicians have helped in the first step of defusing the nuclear threat, so can they become champions of true security in the world. True security comes from having a fair chance at having children survive to school age, then adulthood, and finally old age. Real security comes in knowing that the science available to medicine can be made available, even to the poor, even in a third world country. Real security comes in not contracting polio and serving a life sentence of unusable limbs. Real security comes in having a chance to eat today without constant worry about malnutrition tomorrow. The world will listen to physicians and sometimes even politicians listen to physicians. That gives us a power we must use wisely.

Polybius was right. It is all intertwined. ■

***‘The International Physicians for the Prevention of Nuclear War has . . . educated many to the senselessness of a kill potential that is beyond comprehension. The cofounders . . . briefed General Secretary Gorbachev. . . .’***



## *She Comes From a Nice Family*

Alfred A. Messer, M.D.

**‘Visiting in the prospective mate’s home of origin allows each partner to experience the mothering, fathering, and the values and ideals to which the intended was exposed.’**

**I** ATTENDED A WEDDING one Sunday and late in the evening, as the bride and groom dashed to a waiting car, we all threw rice and rose petals. The bride’s father, a distinguished orthopedist and friend of many years, turned to me and asked, “Do you think it will last?”

Now that half of all recent marriages end in divorce, engaged couples seek advice about how to avoid that unhappy event. How will they resolve conflicts, small and large, that inevitably take their toll on marital harmony? Most couples say, “We’ll see what the issues are, try to reach some understanding and compromise, and go from there.”

It doesn’t work that way. How we deal with conflict is mainly a carry-over from what we experienced growing up. If parents withdrew into silence after they had a spat, a child exposed to this pattern will probably repeat the behavior in his or her own marriage. If the parents went at each other with ringing shouts and curses, it’s likely that this would happen among kin in a new union as well.

**M**y prescription for an enduring marriage: each engaged person should live with

the family of the intended spouse for a week at some point prior to marriage to learn about personalities in the family or origin. Who were the role models for *imitation* and *identification* in early life and how did they handle family conflicts?

The phrase “she comes from a nice family” describing a man’s fiancée may refer to social, cultural, or economic status. More importantly, in a “nice family” was her early life reasonably harmonious, with parents and siblings or extended family allowing opportunities for healthy imitation and identification? Did both sides manage her trek through adolescence without lasting disruption? Were severe problems in one family member offset by another’s evenness, thus diminishing the likelihood of troublesome identifications among children that would disturb their own marriages later on?

**A** couple sought help after their marriage of 9 years had fallen apart. They married after graduation from college in the same class, and the wife worked at an Army base overseas for 2 years to be near her soldier-husband. Neither felt comfortable with their in-laws, so there was

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minimal contact between the generations. "We have each other and that's enough," they reassured themselves.

Yet this seemingly contented marriage foundered when their only child reached 5. The wife, reared in an old New England family, expected that the boy would attend private schools and then go on to the same college as her father and grandfather had. The husband, son of immigrant parents, was just as adamant that the child go to public schools, "so that he'll know how to get along with everybody. That's what my parents gave me and it worked. He ought to have the same chance."

Neither would compromise. In the end, lawyers and judges would decide the fate of the child.

How different the sequence might have been from the beginning, if the couple had extensive exposure to the spouse's home of origin. Each could then have understood the imitative aspects of their behavior.

**W**e imitate someone consciously. Almost every family album has a picture of a boy struggling to walk in his father's shoes, or that of a girl wearing her mother's old party

dress. A year later, when these children are asked casually about their careers as adults, they usually pick the vocation of mother and father. In identification, we subconsciously internalize parental behavior and attitudes by attaching to our own egos certain qualities or values associated with these figures. Positive identification involves fusion with the loved part of the parent.

In hostile identification, the child exposed to a fearsome parent may internalize the hated or undesired part of the parent as a way of neutralizing aggressive behavior. For example, I was asked to treat a youth of 17 who had accumulated three DULs in less than a year. Keith had a part-time job so it was important that he drive. He was a good student, a varsity athlete, and he enjoyed school dances. His father had always imbibed two evenings a week and became a "mean and nasty" drunk. The mother, my patient, and two younger siblings contested him bitterly during these long nights, repeatedly telling him about their hatred and disgust of alcohol.

Keith started driving at 16. When asked why he began drinking heavily, an activity he had always despised, he shrugged

and answered, "I didn't mean to do it. I couldn't help it." Now, he was bringing down the wrath of society as well as his family upon himself.

Identification is the most important of all the psychologic mechanisms in determining healthy growth of the child's ego. The child molds himself in accordance with his view of the parents and significant others. He identifies himself with certain values and beliefs in the adult and these become the basis for his own adult conscience.

Therefore, visiting in the prospective mate's home of origin allows each partner to experience the mothering, the fathering, and the values and ideals to which the intended was exposed. Did the parents demand excellence in every endeavor? Was artistic achievement treasured over financial success? Were firm roots in one locale necessary, or could one pick up and move as new opportunities arose? Was adventure more valued than security?

The mate's behavior is then more understandable, particularly during conflicts, and these can be resolved more readily. Growth occurs. The marriage itself is more viable. ■





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# A One Megaton Nuclear Explosion Over Atlanta—The Immediate Effects

Jonathan E. Kaplan, M.D.  
T. Stephen Jones, M.D., M.P.H.  
Ed Biel

***This article describes the immediate effects, in terms of deaths and injuries, of the detonation of a one megaton nuclear weapon (equivalent to the explosive force of one million tons of high explosive) over the city of Atlanta.***

*The authors are affiliated with the Centers for Disease Control, Atlanta, Georgia. This article is written in their private capacity. No official support or endorsement by the U.S. Public Health Service or the U.S. Dept. of Health and Human Services is intended or should be inferred.*

**T**he modern world is poised for nuclear war. Despite recent progress in arms control negotiations, the United States and the Soviet Union still possess nuclear weapons that number in the tens of thousands. Delivery systems have been refined such that thermonuclear warheads can reach their targets with pinpoint accuracy. At this moment, thousands of nuclear warheads are aimed at the United States and could reach their targets in about 30 minutes, considerably less for weapons launched from submarines off the coast of North America. In an international crisis, or in a situation involving computer malfunction or

human error, an exchange of nuclear weapons could occur. Yet few people are aware of the magnitude of destruction that would result from the explosion of one of these weapons.

This article describes the immediate effects, in terms of deaths and injuries, of the detonation of a one megaton nuclear weapon (equivalent to the explosive force of one million tons of high explosive) over the city of Atlanta.

## **Background on Nuclear Weapon Explosion**

To understand the destructive effects of a nuclear weapon, one must first understand the events that occur when a weapon is detonated.<sup>1</sup> Initially, there is a release of ionizing radiation, termed "prompt" radiation, followed by a blinding flash of light and a release of thermal energy (heat) as a fireball forms at the point of the explosion (epicenter). The temperatures generated are on the order of thousands of degrees Fahrenheit. A blast wave, similar to a shock wave, then

radiates outward from the epicenter. The intensity of this wave is usually described in pounds of overpressure (the pressure in excess of atmospheric pressure) per square inch (psi). The blast wave is followed by high velocity winds initially blowing at hundreds of miles per hour. Finally, radioactive debris created by the explosion settles back to earth in the form of radioactive fallout.

The immediate effects on humans of a large thermonuclear explosion are caused primarily by the thermal energy and the blast wave generated by the explosion.<sup>2</sup> The "prompt" ionizing radiation generated during the explosion of a one megaton weapon would cause significant radiation illness only in areas near the epicenter; persons who might be affected by "prompt" radiation would be killed by blast and heat. Radioactive fallout would cause significant morbidity and mortality in the hours, days, and weeks following the explosion.

The intense heat generated by the explosion would either vaporize per-

**To understand the destructive effects of a nuclear weapon, one must first understand the events that occur when a weapon is detonated.**



sons close to the epicenter or burn them beyond recognition; those farther away would suffer "flash burns" on skin directly exposed to the explosion. Within a few miles of the epicenter, temperatures would be high enough to ignite clothing spontaneously, causing "flame burns" in addition to the flash burns. Such combinations of flash and flame burns were observed among victims at Hiroshima.<sup>3</sup>

Within 1 to 3 miles of the explosion, the blast wave would destroy everything in its path including buildings. The high velocity winds that follow would hurl building debris, such as concrete, stone, wood, and glass fragments, through the air at hundreds of miles per hour. Objects would be blown into people and people into objects, generating a wide variety of traumatic injuries: crushed chests and extremities, skull fractures, penetrating wounds of the chest and abdomen, ruptured lungs and other internal organs, crushed vertebrae and transected spinal cords, multiple lacerations and profound hemorrhage.

The location of the explosion—whether in the air or at ground level—affects the magnitude of the heat and blast effects and the amount of radioactive fallout. Weapons exploded at ground level are intended to destroy hard targets such as missile silos. In such "ground bursts," the explosion creates a large crater, and a large volume of soil is drawn up into the mushroom-shaped cloud. The soil becomes coated with radioactive material, which settles back to earth within hours to days as local fallout. Hence, a ground burst, in addition to destroying hard targets, might also be used to maximize local radioactive fallout.

Weapons aimed at population centers would generally be exploded several thousand feet above the target. For a given yield of weapon, the thermal and blast effects of such an "air burst" are greater than for a ground burst. In an air burst explosion, however, the fireball does not touch the ground and local fallout is minimal (although some may occur due to precipitation). Most of the radioactive material is lifted into the stratosphere, from where it settles to earth months or even years later as distant fallout. The nuclear explosions at Hiroshima and Nagasaki were both air bursts.

#### **Nuclear Explosion Over Atlanta—Model**

In this illustration of the effects of a nuclear explosion, a one megaton weapon would be exploded at approximately 6500 feet altitude (an air burst) over Five Points (Woodruff Park) in downtown Atlanta. (Five Points is designated ground zero, or the hypocenter—the point directly beneath the epicenter of the explosion.) The distances from the hypocenter at which varying degrees of blast wave damage would occur (Figure 1) are estimated based on numerous tests of weapons in the atmosphere prior to the partial Nuclear Test Ban Treaty of 1963.<sup>1</sup> The thermal effects, specifically the severity of burns that would occur in those directly exposed to the explosion, are somewhat less predictable, since they would depend on weather conditions at the time of the explosion. Clear weather allows maximum transmission of thermal energy generated by the weapon; cloudy, foggy, or rainy weather would diminish it.

The casualties resulting from the explosion are difficult to estimate and

depend on a number of factors. In this model, we assume that people will be at home at the time of the explosion. The numbers of people living within each concentric ring (Figure 1) were determined using 1980 census figures, estimating the percentage of the land area of each census tract within each concentric ring and assuming uniform distribution of the population in each census tract. An explosion during business hours on a workday, because of the greater concentration of people in the downtown area, would cause higher casualties than indicated in our estimates. Conversely, if there were sufficient warning for significant numbers of people to leave the center of Atlanta before the explosion (a highly unlikely event), fewer people might be injured or killed. The season, the time of the day, and the weather would also affect the casualty estimates. (People outside buildings would sustain more thermal injuries than those indoors, so thermal injuries would probably be increased on a pleasant day in a warmer month. Conversely, those inside buildings would likely suffer more injuries from the blast wave. Hence, blast injuries might be greater during business hours, at night, or in cold weather.)

We have estimated only the casualties that would occur immediately, within minutes of the explosion. They are derived from a model for a one megaton ground burst<sup>4</sup> and scaled up such that the lethal area, defined as the area within which the number of survivors would equal the number killed outside the area, would correspond to the area within 4.3 miles of the hypocenter.<sup>5,6</sup>

#### **Estimates of Destruction and Injury**

**Within 1 to 3 miles of the explosion, the blast wave would destroy everything in its path including buildings . . . The high velocity winds that follow would hurl building debris . . . Objects would be blown into people and people into objects . . .**



**RING 1:** radius 1½ miles. Within this ring, the blast wave overpressure would exceed 20 psi; all buildings, including those made of steel or reinforced concrete, would be demolished. Winds would exceed 500 mph. Anyone exposed directly to the direction of the epicenter would either be vaporized or burned beyond recognition. All persons would be killed.

**RING 2:** radius 1½ to 3 miles. Within this ring, overpressure would be 10-20 psi. All buildings, with the possible exception of those made of steel or reinforced concrete, would be destroyed. Wind velocity would be about 300 mph, enough to hurl 180-pound adults 300 feet or more at high speeds. Persons exposed directly to the direction of the epicenter would be burned beyond recognition. Approximately 98% of persons would be killed; the remaining 2% would be injured.

**RING 3:** radius 3 to 4 miles. Within this ring, overpressure would be 5-10 psi. Stone and concrete buildings might remain standing, but brick and wood frame houses would be destroyed. Wind velocity would be 160 mph, enough to hurl an adult 20 feet at 14 mph. Persons directly exposed to the direction of the epicenter would receive 3rd degree burns to exposed skin; clothing would ignite spontaneously. Eighty percent of persons would be killed; the remaining 20% would be injured.

**RING 4:** radius 4 to 5 miles. Within this ring, overpressure would be 4-5 psi. Brick and frame houses would be destroyed or severely damaged. Wind velocity would be 125 mph—greater than hurricane force. Exposed persons would receive 3rd degree burns to exposed skin; clothing would ignite spon-

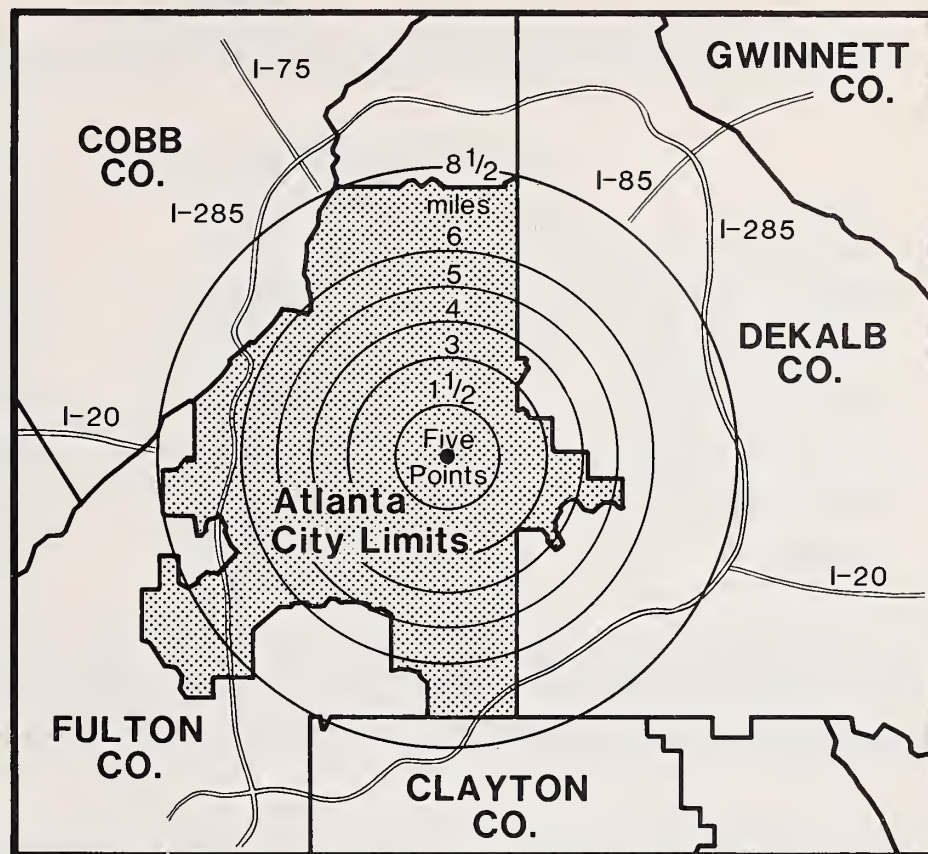


Figure 1—Map of Metropolitan Atlanta showing concentric circles at 1½, 3, 4, 5, 6, and 8½ miles from the hypocenter (the point directly beneath the explosion) at Five Points (near Woodruff Park) in downtown Atlanta.

taneously. Forty percent of persons would be killed, 55% injured.

**RING 5:** radius 5 to 6 miles. Within this ring, overpressure would be 3 psi; brick and wood frame houses would be severely damaged. Wind velocity would be about 100 mph. Exposed persons would receive 3rd degree burns to exposed skin. Two percent of the people would be killed, 60% injured.

**RING 6:** radius 6 to 8½ miles. Within this ring, overpressure would be 2 psi; brick and wood frame houses would be moderately damaged (structure

cracked, glass broken, inside walls knocked down, roofs partly torn off). Wind velocity would be 70-80 mph. Smaller pieces of debris would still be lethal missiles, and windows would fragment into glass shards traveling at speeds close to 100 mph. Exposed persons would receive 2nd degree burns to exposed skin. There would be few deaths, but 25% of the people would be injured.

The estimated deaths and injuries resulting from this explosion are shown in Table 1. An estimated 255,000 persons would be killed outright; an additional 184,600 would be injured.

**An estimated 255,000 persons would be killed outright; an additional 184,600 would be injured . . . The USACDA casualty estimates for a 1 megaton explosion are considerably higher than those in our model.**

**Table 1****Estimated Immediate Casualties Resulting from a One-Megaton Nuclear Air Burst Over Downtown Atlanta\***

	<b># Persons Killed (%)</b>	<b># Persons Injured (%)</b>	<b>Total Resident Population</b>
<b>Ring 1 (radius 1½ miles)</b>	<b>42,000 (100)</b>	<b>—</b>	<b>42,000</b>
<b>Ring 2 (1½ to 3 miles)</b>	<b>100,500 (98)</b>	<b>2,000 (2)</b>	<b>102,500</b>
<b>Ring 3 (3 to 4 miles)</b>	<b>72,700 (80)</b>	<b>18,200 (20)</b>	<b>90,900</b>
<b>Ring 4 (4 to 5 miles)</b>	<b>37,800 (40)</b>	<b>52,000 (55)</b>	<b>94,500</b>
<b>Ring 5 (5 to 6 miles)</b>	<b>2,000 (2)</b>	<b>59,600 (60)</b>	<b>99,400</b>
<b>Ring 6 (6 to 8½ miles)</b>	<b>—</b>	<b>52,800 (25)</b>	<b>211,000</b>
<b>TOTALS</b>	<b>255,000 (40)</b>	<b>184,600 (29)</b>	<b>640,300</b>

\* Assumes detonation at approximately 6,500 feet altitude over Five Points (Woodruff Park) in downtown Atlanta. Estimates of casualties are based on 1980 census figures and assumes that all residents are at home at the time of the explosion.

### Discussion

The number of immediate casualties resulting from this one megaton bombing of Atlanta would not be limited to those caused by the thermal energy and blast wave. A massive fire would almost certainly occur following the explosion as a result of blast damage to fuel tanks, boilers, stoves, and furnaces, the release of combustible material into the environment, spontaneous ignition by the high temperatures generated by the thermal radiation, and the high winds generated by the blast wave. Such a firestorm burned for several hours after the explosion at Hiroshima, inflicting additional burn casualties and suffocating persons trapped in closed spaces.<sup>7</sup> Following a one megaton blast, a firestorm could engulf the area

within 7½ miles of the hypocenter, thus adding significantly to the estimated casualties.<sup>6</sup>

Because weapons of many different yields are deployed in current nuclear arsenals, we investigated how casualty estimates would be affected by changes in the yield of the weapon. In 1980, the U.S. Arms Control and Disarmament Agency (USACDA) published estimates of deaths and injuries that would result from nuclear explosions over U.S. cities.<sup>8</sup> The estimated casualties for 200 kiloton, 500 kiloton, 1 megaton, and 5 megaton airburst explosions over Atlanta (Table 2) indicate the differences in estimated casualties for thermonuclear weapons of varying yields. The USACDA casualty estimates for a 1 megaton explosion (363,000 deaths, 350,000 injuries) are consider-

ably higher than those in our model (255,000 deaths, 184,600 injuries). The differences may be attributed in part to the fact that the USACDA model attempted to maximize casualties by exploding the weapon over areas of greatest population density, rather than simply the center of downtown Atlanta. Nevertheless, the differences are instructive because they demonstrate the wide variation of casualty estimates and the possibility that our estimates are conservative.

Our model of a single nuclear detonation over Atlanta is probably unrealistic. A nuclear attack on the Atlanta area would almost certainly involve multiple warheads aimed at industrial centers (such as Lockheed Georgia Co.), military facilities (Fort MacPherson, Fort Gillem), airfields

**Our model of a single nuclear detonation over Atlanta is probably unrealistic. A nuclear attack on the Atlanta area would almost certainly involve multiple warheads aimed at industrial centers . . . military facilities . . . airfields . . . and population centers.**



## Table 2

**Estimated Deaths and Injuries Resulting From a Single Air Burst Thermonuclear Weapon Over Atlanta, By Yield of Weapon in Kilotons**

	Yield in Kilotons of High Explosive			
	200	500	1000	5000
Deaths	97,000	190,000	363,000	720,000
Injuries	178,000	320,000	350,000	341,000

Source: U.S. Arms Control and Disarmament Agency<sup>8</sup>

(Dobbins Air Force Base, Hartsfield International Airport), and population centers. The attack would probably involve a combination of air bursts over population centers and ground bursts to maximize radioactive fallout. The effects of these weapons would overlap and would increase the area affected by blast and heat many-fold compared to the area that would be affected by a single weapon.

Despite the magnitude of error inherent in estimating the numbers of dead and injured in this one megaton explosion, the uncertainties in the number and in the yield of the weapons that would be used in a nuclear attack on Atlanta, and the possible effects of a firestorm, it is clear that the number of casualties and the level of destruction resulting from the bombing would be unprecedented. Following the explosion, many of the

injured and uninjured would perish in the ensuing days because of lack of medical care, exposure, radiation injuries, and dehydration. The inadequacy of the medical care that would be available after the hypothetical one megaton explosion over Atlanta is discussed in the following companion article in this issue by Koplan and Jones.<sup>9</sup>

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The authors thank Martha Rogers M.D., and Alfred Lieberman M.S., for assistance with the casualty estimates.

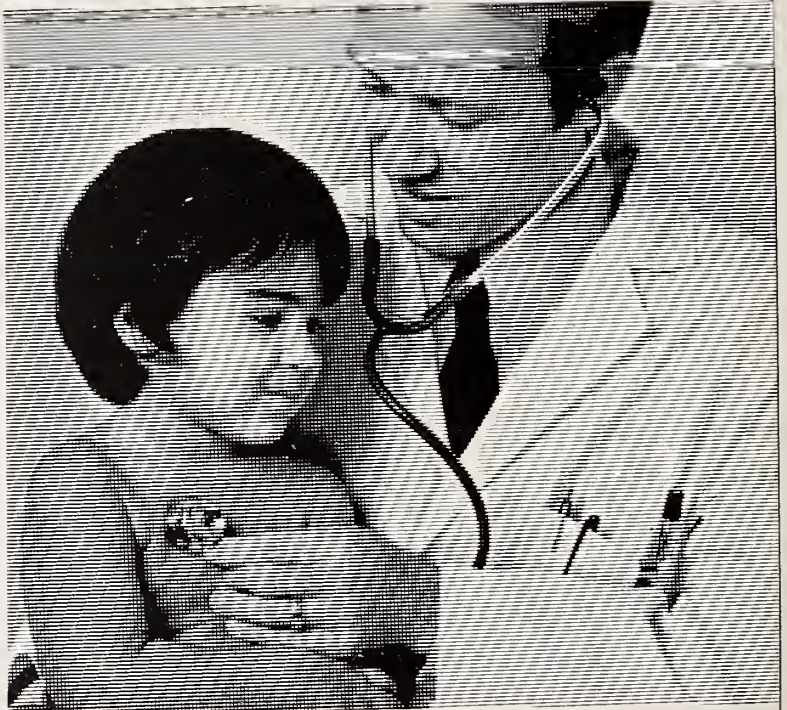
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# Health Care Consequences for Atlanta of a Nuclear Explosion

Jeffrey P. Koplan, M.D., M.P.H.

T. Stephen Jones, M.D., M.P.H.

*This article describes the effect on the medical infrastructure of the detonation of a one megaton nuclear bomb over Atlanta and the implications of this scenario on the posture of the health care community towards the prevention of nuclear conflict.*

*Drs. Koplan and Jones are employed by the Centers for Disease Control (CDC), an agency of the U.S. Public Health Service (PHS), located in Atlanta. The paper represents their personal views; it does not represent any position or policy of the CDC or PHS.*

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## Introduction

As described in the preceding article by Kaplan, et al,<sup>1</sup> a one megaton nuclear bomb explosion would probably kill nearly 230,000 Atlantans immediately and injure over 170,000 more. Longer-term radiation effects would begin to cause illness within days in hundreds of thousands more people. The capability of the health community to respond to such a disaster and the proper role of the physician in preventing such an occurrence should be examined. Who would be available to provide medical

care? Where would they provide it and with what equipment and materials?

The organization of modern medical care in the U.S. makes the system vulnerable to disruption—such as the concentration of our medical resources in large population centers (primary targets of nuclear attack), medical specialization and subspecialization, medical dependency on technology for diagnosis and treatment, and the importance of transportation and communication in gaining access to medical care. In this article, we discuss the effect on the medical infrastructure of the detonation of a one megaton nuclear bomb over Atlanta and the implications of this scenario on the posture of the health care community towards the prevention of nuclear conflict.

## Methods and Materials

The hypothetical scenario we consider is based on that used by Kaplan, et al,<sup>1</sup> i.e., a one megaton nuclear air burst explosion over downtown Atlanta (Five Points) occurring after daytime work hours, in clear weather skies. Six

concentric rings of decreasing destructive intensity are considered, from Ring 1 with a radius of 1.5 miles from ground zero (the point directly beneath the explosion) to Ring 6 with a radius of 8.5 miles. (See Table 1 in Kaplan article for levels of destructive effect.)

The Georgia State Health Planning Agency provided estimates of hospital beds by county, and the Medical Association of Georgia provided estimates of its member physicians by county which we adapted to location in rings around ground zero (Table 1).

We assumed the levels of damage would occur based on U.S. Government estimates.<sup>2</sup> We assumed that after routine work hours 25% of physicians would be in hospitals or offices, and 75% would be near or at home. We further assumed that most physicians live in suburban Atlanta; 2% in Ring 1, 3% in Ring 2, 7% in Ring 3, 8% in Ring 4, 20% in Ring 5, 30% in Ring 6, and 30% outside the 8.5-mile radius.

## Results

Of the approximately 7,600 non-psychiatric hospital beds in Metro-

**It is difficult to imagine 1,640 physicians and associated health workers providing any semblance of care for 172,500 injured persons, while hampered by lack of facilities, equipment and supplies, poor communication and transportation, and basic utilities such as electricity and water.**

**Table 1**  
**Hospital, Physicians, and Effects of Nuclear Explosion**  
**by Distance from Ground Zero**

Ring	Radius (Miles)	Hospitals	Beds	Physicians*	Effects
1	1.5	Atlanta Crawford Long Doctors Memorial Georgia Baptist, Grady Hughes Spalding, Midtown	2001	96	Complete destruction and loss of life
2	3	Jesse Parker Williams	50	61	Near complete destruction and loss of life
3	4	Piedmont	448	168	Medical facilities unusable, staff disabled
4	5	Emory, Egleston	753	209	Severe damage to facilities, staff disabled
5	6	Veterans Administration, Decatur, Metropolitan Eye	1337	483	Damage to facilities, 50% of staff functional
6	8.5	DeKalb General	411	601	Facilities and staff functional

Beyond 8.5 miles, there are 2,595 beds and approximately 800 physicians in the Metropolitan Atlanta area.

\*See *Methods* for computational basis.

politan Atlanta, 2,499 in Rings 1-3 would be totally destroyed or unusable (Table 1 and Figure 1). A further 2,090 beds in Rings 4 and 5 would be in severely damaged facilities. Potentially usable hospital facilities would include the 411 beds in Ring 6 and about 2,600 hospital beds more than 8.5 miles from ground zero.

Of the approximately 2,500 practicing physicians in the area, 157 would be killed immediately in Rings 1 and 2; 377 would be killed or incapacitated in Rings 3 and 4; and possibly 50% of the 483 physicians in Ring 5 would be able to perform their duties. Thus, including those of Ring 6 and outside the 8.5-mile radius, there might be approximately 1,640 physicians available for patient care. This represents over 100 severely injured persons per function-

ing physician and 60 patients per hospital bed on day one.

### Discussion

The number of remaining hospital beds and physicians (with a comparable remaining fraction of nurses, technicians, and other health care workers) reveals only a small part of the difficulties in delivering post-detonation medical care. The blast, high winds, and fire storm would extensively damage buildings, roads, and the social infrastructure of Atlanta. Electrical power, water supply, sewage, and solid waste disposal would all be disrupted. Transportation would be impaired by impassable roads, damaged vehicles, and shortage of fuel. Communication via television, radio, or telephone would be impaired by

destroyed studios, transmission facilities, and inoperative receiving equipment. The electromagnetic pulse that follows a nuclear explosion would destroy microelectronic circuitry and any equipment using transistors or chips, up to approximately 9 miles from ground zero.

Similarly, this electromagnetic pulse would adversely affect medical equipment in hospitals/offices, etc., from EKG machines to x-ray units to blood chemistry analyzers.

Even if only a fraction of the estimated 172,500 injured, many seriously, get to medical care facilities, supplies from gauze pads to suture material to antibiotics and blood for transfusion would be rapidly exhausted. Most hospitals maintain only a one-week supply of such materials.

**For physicians, this subject (prevention of nuclear war) need not  
be a partisan political issue or a liberal vs. conservative one.  
Rather, a basic supposition is that the human suffering  
and death would be a tragedy and could be barely aided by  
a devastated medical establishment.**



The Red Cross has a target blood supply of 6,000 units for Atlanta. However, at times the available supply is only about half of this goal. Under normal conditions this supply would be expected to satisfy demand for 6-10 days (personal communication, Dr. A. Grindon). Even if only 5% of the 172,500 injured were given a single unit of blood, it is obvious that available blood for transfusion would be inadequate to meet needs. Indeed, the severe lacerations, internal injuries, and burns likely to be seen would require multiple units of blood products for each patient.<sup>3</sup> In addition, the Atlanta Red Cross blood bank is located in Ring 3 and would be severely damaged.

Many of the tens of thousands severely injured will suffer from extensive third degree burns (and even more second degree burns). With only approximately 1,500 specialty burn unit beds in the entire U.S., only a handful of those in need of care will obtain appropriate treatment. The Atlanta area has approximately 26 burn unit beds at Grady Memorial Hospital which would be destroyed.

It is difficult to imagine 1,640 physicians and associated health workers providing any semblance of care for 172,500 injured persons, while hampered by lack of facilities, equipment and supplies, poor communication and transportation, and basic utilities such as electricity and water. Obviously, many will die of severe and even less severe injuries without obtaining any medical care. Additionally, a scenario that envisions selfless physicians working around the clock to help the injured does not take into account that many physicians will be unable to get to hospitals and clinics. Many others will stay home to care for their family and neighbors.

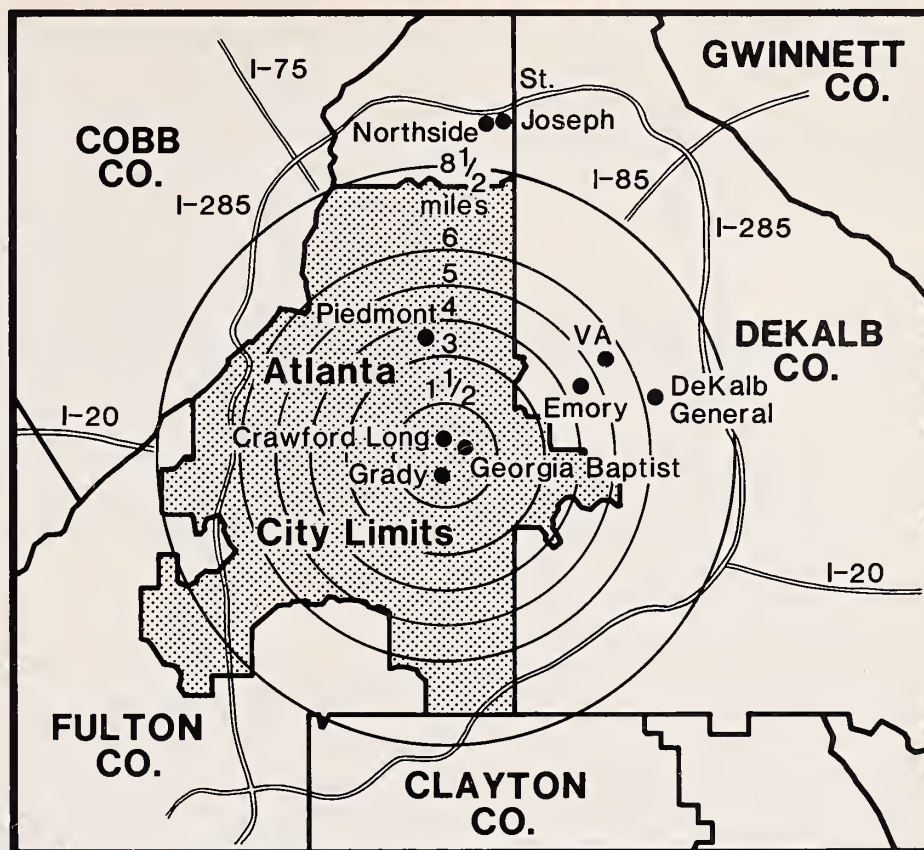


Figure 1—Map of Metropolitan Atlanta showing concentric circles at 1½, 3, 4, 5, 6, and 8½ miles from ground zero (the point directly beneath the explosion) at Five Points (near Woodruff Park) in downtown Atlanta. Several of the area hospitals are included for reference.

After the explosion, delayed onset casualties, largely due to radiation illness, would appear. The ranks of the remaining health care workers would be steadily depleted as they themselves are affected by radiation illness and are further distracted from professional duties by family and personal living concerns. The Chernobyl nuclear disaster has shown that even with intensive high technology care, serious radiation exposure responds poorly.<sup>4</sup>

Further contributors to the deteriorating health conditions would be problems of food provision and distribution, availability of potable water, sewage disposal, disposal of human and animal corpses, and the continued

collapse of modern transport, communications, and utilities.<sup>3</sup> The long-term health sequelae of such a nuclear explosion largely involve radiation toxicity, disruption of the food chain, other ecologic and environmental disruptions, and profound social and psychological stress.<sup>5</sup>

It should be noted that the model we have discussed considers the effects of only one nuclear bomb explosion. A more realistic scenario would involve multiple warheads aimed at several potential targets in greater Atlanta, e.g., Fort MacPherson, Dobbins Air Force Base, Fort Gillem, and Hartsfield Airport. In addition, it is unlikely that medical assistance would

**We believe that reducing the risk of nuclear war is a legitimate public health concern and that physicians could be instrumental in working towards its prevention.**

be available from other localities which themselves would be likely targets of attack—e.g., King's Bay, Fort Benning, Fort Stewart, Warner Robins Air Force Base, and industries and airports in neighboring cities.

**W**hat is the appropriate medical response to a disaster such as we describe?

It is clearly impossible and inappropriate to attempt to train staff, build and maintain additional health facilities, and acquire supplies for a possible nuclear attack. The expenditure is beyond our economic resources. Could civil defense measures, including evacuation of the population, prevent many of the casualties? This has been addressed in detail by others and considered to be an inadequate and impractical approach.<sup>6,7</sup> One perspective is that "where treatment of a given disease is ineffective or where costs are insupportable, attention must be given to prevention."<sup>8</sup>

Physicians tend to follow Benjamin Franklin's maxim and consider prevention as preferable to palliative treatment. A challenge for us is to identify practical and effective preventive measures. For example, screening for early breast cancer and childhood immunizations are preventive approaches that are now routine aspects of sound medical practice. Physicians are increasingly involved in health education and promotion efforts for their patients and the public—smoking cessation, weight loss, good nutrition, exercise, seat belt use, etc. Physicians and all health workers could similarly speak to patients, the public, community and government leaders on

the risks of nuclear war and advocate societal and governmental activities that will prevent nuclear war. For physicians, this subject need not be a partisan political issue or a liberal vs. conservative one. Rather, a basic supposition is that the human suffering and death would be a tragedy and could be barely aided by a devastated medical establishment. The highly regarded and depended upon quality of medical care now available in the U.S. will be tragically (for both the injured and their physicians) inadequate against such widespread destruction.

**T**his paper demonstrates the magnitude of the public health and social disaster that would result from the explosion of a single thermonuclear weapon over Atlanta. We believe that reducing the risk of nuclear war is a legitimate public health concern and that physicians could be instrumental in working towards its prevention. As they have with other medical/health catastrophes, a reasonable first step is self-education, and a number of recent publications can be helpful toward this end.<sup>6,9,10</sup>

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**The highly regarded and depended upon quality of medical care now available in the U.S. will be tragically (for both the injured and their physicians) inadequate against such widespread destruction.**



# Unity — Facing the RVS

Harrison L. Rogers, Jr., M.D.

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**The resource based  
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provide an accurate  
and fair relationship  
between an office visit  
for chicken pox and a  
heart transplant, taking  
into account all  
identifiable resources  
in the provision of each  
service.**

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**O**UR PROFESSION, the product we deliver, the health care system itself has undergone revolutionary changes in the past 30 years with spectacular advances in the diagnosis and treatment of nearly all health problems. The product we deliver in the United States is unquestionably the "gold standard" for the world, with steadily increasing longevity and decreasing death rates from all diseases. Our diagnostic capabilities are growing with new radiologic and endoscopic techniques available in nearly every hospital in the state. Our therapeutic capabilities are equally impressive with new drugs, from vaccines for polio to the unbelievable array of antibiotics and cardiac drugs. Our surgical advances from anesthesia and microsurgery to organ transplantation are just as impressive.

Our health care system has grown dramatically during this same period until today it is the second largest industry in our country, employing over 8 million people. In Minnesota, health care is the largest industry in the state, and in Cleveland, Ohio, it is the largest industry in that city. We now have over 500,000 physicians, 1.5 million nurses, 7,000 hospitals, 20,000 nursing homes and 235 million patients!

With advances in medicine and the increase in size of our system, the cost is up as well. It has grown from 43 billion dollars in 1965 to 500 billion dollars today. Health care cost is a critical issue for industry, government, and the public. Congress is desperately searching for an answer to the federal deficit, industry is searching for an answer to their declining profits, and the public must face increases of 20 to 30 percent in their health insurance premiums. The cost of health care

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Dr. Rogers, Past President of the AMA, practices general surgery. His address is 35 Collier Rd., Suite 670, Atlanta, GA 30309.

is a major issue on all fronts in 1988, and since the government buys 40 percent of the total health care provided in our country, whatever it does to remedy this problem has a direct effect on our entire system. Medicare is spending \$2500 on each beneficiary this year, and while the increase in Part A (which pays the hospital) has slowed somewhat, Part B (which pays physicians) has continued to rise rapidly. Congress and the Health Care Financing Administration are focusing on you and me!

New methods of paying for care are in place, with capitation systems (HMOs, PPOs, etc.) increasing their numbers, even though some have had disastrous problems in the past year. Today, nearly 30 million people are enrolled in them, including 1 million Medicare recipients, and HCFA is pushing hard for increasing this number. Industry is actively supporting Managed Care Plans which provide the cost advantage of HMOs without their large administrative costs. Both systems succeed with tight Utilization Review, and the managed care plans are trying hard to enlist practicing physicians as their unpaid agents for pre-admission certification, concurrent review, and discharge planning.

The corporatization of medicine is occurring at the same time in response to increased competition between physicians, spending limits in health care, and the ascendancy of third party payors whether government or private. More physicians are in group practices, more are employed, and all have pressure from the fiscal officer of their organization to "spend less money" on their patients! It is imperative that each of us resist this "business ethic" and hold tight to our "professional ethic" where we are in *fact* our patient's advocate! As corporatization increases, separation from our patients is enhanced but must be actively opposed, for the patient needs our help, and surely in the times ahead we will need our patients' help as well.

Legislative issues, both state and national, continue to warrant our close attention. The MAG Legislative Council described 1988 as the year of the "attack" on our profession. Proposed national legislation to mandate "participating physician" status for Medicare, catastrophic coverage (to include a cap on all health expenditures), and long-term care are but a few selected items. "Reform" of payment mechanisms for physicians remains an issue for continuing debate in the Congress, with the resource based *Relative Value Scale* as the major vehicle in the debate.

**R**elative Value Scales or Schedules have been in existence for years, with the California RVS being the prototype. These studies took physicians' charges for specific services and simply converted the dollar charge to a representative numerical value. These values were then accumulated into a single volume to include all available specialty charges and were used by physicians in setting their fees until the RVS was banned by the Federal Trade Commission. From 1983 to 1985, the AMA House of Delegates debated physician reimbursement, with their focus on the absence of a rational relationship between services of physicians who performed procedures and those who

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**If the resource based RVS is found to be fair, accurate, and workable, it deserves the unified support of every specialty, winners and losers, and there are certain to be both.**

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did not. This was a very difficult issue to resolve because it directly related to the amount of money to be paid for physician services, whether pediatrician or cardiac surgeon. The numbers of dollars involved were impressive!

**S**imultaneously, Congress passed an extensive revision of the way it paid hospitals (the prospective pricing system, or DRG system) and wrote into that law a mandate for the Department of Health and Human Services to develop a *resource based RVS*. This new scale was to provide an accurate and fair relationship between an office visit for chicken pox and a heart transplant, taking into account all identifiable resources in the provision of each service. These resources would include time involved, severity of illness, complexity of the problem, education and training required, malpractice liability, and all the identifiable costs associated with the provision of a particular service. With passage of this law, the AMA House of Delegates approved submission of an application to become the contractor for this study. HHS then decided that this study would have to be done outside the profession and the AMA, the American College of Surgeons, and the American College of Physicians all joined with universities making applications for this contract.

Dr. Hsiao of the Harvard School of Public Health was given the contract in April, 1986, with the AMA named as adviser. The contract calls for the completion of the study in

July, 1988, and the study is proceeding on schedule. There have been 18 specialty panels developing the relative value of all services provided within each specialty, and simultaneously cross specialty panels have been at work searching for "linkages" between specialties. Their goal is to find multiple areas between specialties where a clear and accurate relationship exists, linkages which can then be translated into relative value of all services both groups provide. It is anticipated that these linkages will provide a relationship between all 18 specialties at the completion of the study.

The AMA's role has been to furnish names of specialists from whom the panels were selected, advising on CPT coding, and advising on methodology. Upon completion this year, the public will be given the study, and the AMA will immediately convene a meeting of specialty societies to evaluate the results. The AMA House of Delegates in December, 1988, will make the decision regarding support or opposition for the study. At a March, 1988, meeting of all those involved with the RVS project, major concerns were voiced including:

1. The RVS will not solve all the problems of physician payment.
2. The prospect that the RVS may have a deleterious effect on access to care.
3. The site where care is delivered may be dramatically changed.
4. Pilot implementation of such a project is mandatory.
5. Negotiations with physicians will be inescapable.
  - a. Good communications within the profession are vital.
  - b. Specialty societies were warned not to break away and "cut a deal."

**U**nity in our profession is a critical need today as we face all the "attacks" described by the MAG Legislative Council and specifically the debate on the resource based RVS report. We have heard from state and federal legislators how easy it is to "divide and con-



quer" when division is already an accomplished fact. We have heard from our officers that there were six separate specialty society lobbyists at the State Capitol at the 1988 Georgia legislative session, each with their own agenda! The British health care system was "sold" to the physicians in England after World War II by the government *exploiting* the schism between specialists and general practitioners. In our own country, as DRGs were proposed for all physicians, we stood together, but when the target was narrowed to the RAPs (radiologists, anesthesiologists, and pathologists), our unity wilted and separate deals were struck with committees of Congress. Harry Schwartz, writing in the 5/6/88 *American Medical News*, eloquently describes the strength of American medicine where it stand together, arriving at compromise's and conciliation before going to the Congress and the public. He also describes the bleak prospects if we continue to seek only our "parochial advantage."

Our legislatures, federal and state, are fighting escalating health care costs and are constantly shown the increasing costs of physician services, not to mention the fabulous income of some of our colleagues.

They literally lick their chops as they view the prospect of solving their problems as they eat us alive!

If the resource based RVS is found to be fair, accurate, and workable, it deserves the unified support of every specialty, *winners and losers*, and there are certain to be both. If the resource based RVS falls short of this goal, then it deserves our *unified* opposition. For those among

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**We heave heard from state and federal legislators how easy it is to divide and conquer when division is already an accomplished fact. We have heard from our (MAG) officers that there were six separate specialty society lobbyists at the State Capitol at the 1988 Georgia legislative session!**

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us who feel the AMA is not a satisfactory representative body, then please immediately organize, finance, and activate an umbrella organization for our profession. This organization should be the essence of democracy with representation in its policy making body on a state and numerical basis as well as having voting representatives of the specialties, armed services, medical schools, students, and residents. This new organization, if it is to replace the AMA as the voice of our profession, must also have the resources in staff and facilities to respond immediately to each and every issue brought to the profession. Such an organization exists today, and this organization is the AMA on a national level and every state association on the state level. These organizations can be our unified voice in every arena if we set aside our parochial advantages. The alternative is a dismal disarray of splintered resources and efforts, *none* effective in protecting the integrity of our profession or the well being of our patients, the American public.

Our only hope lies in unity — with ourselves and with our patients, for they are the electorate and the elected. ■

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# Teaching Internal Medicine in a Community Hospital

John D. Cantwell, M.D.

*Editorial Note: The management of a teaching program in any of the branches of medicine must be for the individual possessed with an inquiring and facile mind one of the most exhilarating experiences to be found. Those of us practicing in institutions without such a training program must all have at one time or the other reflected ruefully upon the absence of daily contact with the young and inquiring physician.*

*William Osler understood the stimulus of the teaching environment when he remarked that, "to study medicine without books is to sail an uncharted sea, but to study medicine without patients is to never go to sea at all."*

*John Cantwell directs the program in Internal Medicine at Georgia Baptist Hospital. His comments are worth reflecting upon.*

SIX YEARS as a program director in internal medicine at a community hospital has given me certain insights as to the joys and challenges of teaching medicine in modern times. The program director is like the conductor of a symphony, setting the mood and giving

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**The program director is like the conductor of a symphony, setting the mood and giving direction, trying to bring out the best performance of each member.**

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direction, trying to bring out the best performance of each member. The duties of a program director include recruitment of new housestaff, structuring the yearly academic program, utilizing practicing physicians with the interest and ability to teach, overseeing the quality of each resident's work, dealing with problems, and keeping abreast of future developments in the field.

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Dr. Cantwell is Program Director in Internal Medicine, Georgia Baptist Medical Center, 300 Boulevard NE, Atlanta, GA 30312. Send reprint requests to him.

## Recruiting New Housestaff

We interview by invitation only, focusing on senior students with satisfactory credentials from reputable medical schools. Unlike some directors, I prefer one-on-one interviews wherein I try to ascertain the personal and humanistic qualities of the applicant. We favor well-rounded individuals who relate well to peers, patients, and teachers, and who are disciplined enough to push themselves scholastically to achieve our ultimate goal of board certification.

The chief resident and I independently interview about 70 applicants between August and November. Twenty-five or so make our match list and the final five selections come from the upper half of the list.

## Structure of the Program

We begin the day with morning report at 7 a.m. This is conducted by the chief resident and a board-certified internist. Management rounds occupy the bulk of the morning. A core curriculum lecture series, covering the whole gamut of internal medicine, is held on Mon-

day and Thursday noons throughout the year. Special topics include sessions on how to lecture and write, pass the boards, and set up a medical practice.

Case-oriented teaching rounds are conducted 3-4 afternoons per week. One of these focuses on cardiology and using stethophones and bedside observation, emphasizes history taking and the physical examination. Videotapes are used in certain instances, when patients have already been discharged, to demonstrate aspects from the history and physical.

Humanistic and cultural aspects of life are emphasized in special monthly sessions. One monthly conference concerns the humanities and features local authorities on art, literature, and music. Our classic-a-month reading club meets for lunch at Manual's Tavern, discussing selections from Fadiman's *The Lifetime Reading Plan*. Residents are required to participate in three of these meetings per year and encouraged to attend all. The Chekhov Society bears the spirit of the Russian physician-author, who demonstrated extraordinary compassion toward the serfs, and prisoners in his country. Resident members in our center do one public service project per year, involving the less fortunate (such as the homeless and the mentally retarded).

Each resident is expected to develop a clinical research project yearly, giving a formal presentation and submitting a paper suitable for publication during a 1-day seminar in June. An annual dinner for the housestaff and teaching attendings is held at the Ritz-Carlton that evening, wherein awards are given for the best paper, resident-of-the-year, and top teaching attending.

#### **Utilization of Private Physicians as Teachers**

Around 70 general internists and subspecialists comprise the teaching attending staff. Ward teams are assigned to the general medicine services for 2-month periods. Sin-

gle residents are assigned to one 2-month subspecialty rotations.

In addition to ward rounds, teaching attendings can participate in morning report, core curriculum lectures, Medical Grand Rounds, case-oriented teaching rounds, and discussion sessions (with 2-4 junior students from the Medical College of Georgia).

Talented teachers from other hospitals are utilized, as our goal is to stimulate the housestaff with exposure to a wide variety of skilled clinicians.

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**Each resident is expected to develop a clinical research program yearly, giving a formal presentation and submitting a paper suitable for publication during a 1-day seminar in June.**

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Residents fill out evaluations of attending physicians after each rotation. The confidential reports are reviewed by the program director. A summary letter is sent to the teaching attending yearly, emphasizing areas of teaching strengths and weaknesses. An attending may lose his or her teaching status if performance remains suboptimal despite self-improvement guidance from the program director.

#### **Surveillance of Residents' Performance**

A structured method of evaluating residents' performance is in effect. Written evaluations on each resident are submitted by students, peers, teaching attendings, nurses, and patients. These evaluations are confidential, reviewed only by the program director and chief resident. Composite letters are sent to residents every 6 months, followed

by individual discussions with the program director.

Fund of knowledge is assessed by written quizzes at the end of subspecialty core curriculum lecture series and through a comprehensive examination in internal medicine each June.

Each resident also undergoes a standardized clinical evaluation exercise, wherein they are observed performing a medical history and physical examination. The session is videotaped so the resident can help judge his or her own performance.

#### **Dealing with Problems**

Certain problems arise that challenge the personal and administrative skills of the director. These can range from domestic problems to personal and/or academic conduct unbecoming of a senior houseofficer. A houseofficer may have to repeat a medicine rotation when his performance didn't meet acceptable standards.

Emotional problems occasionally develop in medical housestaff and are handled discreetly and compassionately, assisted by consultant psychiatrists. Preventive psychiatry is emphasized in at least twice yearly discussion sessions with the housestaff.

#### **Future Developments in Medicine**

Residents are kept abreast of changing trends in medicine, such as increasing governmental control and rising malpractice costs. A mock trial is held yearly, conducted by a local attorney, during which preventive measures about litigation are emphasized. Senior attendings conduct periodic sessions on medical ethics, dealing with a wide variety of situations ranging from "no codes" to "Baby M" cases.

Medicine residents keep procedure logs to document their experience in techniques such as thoracentesis and insertion of Swan-Ganz catheters and temporary pacemakers. They are encouraged to take electives in areas such as



preventive medicine, sportsmedicine, exercise testing, and office aspects of certain subspecialties (gyn, ophthalmology, ENT, orthopedics) so they can bring a wider spectrum of skills to their private practice situations.

The medical literature is vast, and information recall a mounting challenge. A computer terminal was installed in the residents' teaching room to enhance their familiarity with its function and capabilities.

### **Conclusion**

It is an opportunity, a challenge, and a pleasure to guide the medical

education of bright, enthusiastic housestaff. My faith in the future of medicine is strengthened by the usual high quality of their work and their caring attitudes.

The administration at our center seems fully cognizant that housestaff enhance the quality of medicine in the hospital, and contributes financial support (in the form of matching funds for private contributions) to maintain high academic standards. An affiliation with the Medical College of Georgia provides students who are taught by, and who in turn teach, residents and attending physicians. The uni-

versity also provides a resource of expert lecturers on a vast number of topics.

The main strength of community hospitals is that they provide teaching attendings who are in the mainstream of medical practice, who know the practical things to teach, and who by the example of care and devotion to their patients, can serve as excellent role models for the upcoming generation of physicians. ■

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# The U.S. Constitution in Perspective

Judson C. Ward, Jr., Ph.D.

**T**HE ADOPTION OF the U.S. Constitution was one of the most important events in the history of our country. Indeed, it had important implications for all people throughout the world. In the euphoria inspired by observance of the Bicentennial, former Chief Justice Warren E. Berger declared that it "has had as great an impact on humanity as the splitting of the atom." The great English Prime Minister, William E. Gladstone, judged it to be "the greatest single document struck off at one time by the brain and purpose of man." In whatever way it may be judged today, there is little question that it rescued the newly formed league of states from strife and uncertainty in 1789, and that it has provided an instrument of government adequate to govern an expanding nation for a period of 200 years.

Observance of the Bicentennial provides an opportunity to review the circumstances which led to the Constitution and to understand better what the framers had in mind. Such a study should inspire a greater appreciation of the wisdom of the authors, but it should not bring on the mindless worship which 2 centuries of successful history tends to produce. A brief review of some of

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**The qualifications of the 55 men who met during those hot summer months are worthy of note. In a nation whose population was largely unschooled, they were unusually well educated.**

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the essential facts should refresh our memories about the historic events of 1787-1789.

The historian John Fiske set the tone for historic interpretation of the years of the Confederacy which preceded the Constitution when he labelled them "The Critical Period." Modern scholars tend to emphasize the successes rather than the failures of the maligned government under the Articles of Confederation and raise questions as to whether these years were as "critical" as Fiske interpreted them to be.

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**W**hatever the actual conditions which prevailed in 1787, a group of unusual men gathered in Philadelphia in May, with most of them convinced that some stronger form of government was needed. Among the most determined of this group were George Washington and James Madison of Virginia and Alexander Hamilton of New York. The qualifications of the 55 men who deliberated during those hot summer months are worthy of note. In a nation whose population was largely unschooled, they were unusually well educated. In addition to their wide informal readings in history and politics, more than half were college men. Graduates of Princeton outnumbered the rest, with nine, while Yale and William & Mary followed with four each. Harvard claimed three and Columbia two.

Of even greater practical importance than education, however, was their record of experience in government. All of the delegates had held public office of some sort. Seven had served as governors of states; 42 had seen service as Congressmen under the Articles; eight were judges; and eight had signed the Declaration of Independence. James Madison, who merits the title



of Father of the Constitution, was doubtless the best prepared of the delegates from the point of view of reading and study. However, in the final analysis, it was willingness to compromise that proved to be the most valuable qualification of those who worked out the accommodations which made the final document possible.

Charles A. Beard, in his controversial *An Economic Interpretation of the Constitution*, published in 1913, concluded that it was the economic interests of the delegates which outweighed their other concerns. He points out that 41 of them held public securities which they hoped to see more secure; 24 had money out on loan; 11 owned stock in manufacturing or shipping companies; 15 were slave owners; and 14 held stock in land speculating schemes. Beard's thesis provides ammunition for critics of the Founders and dismays those who agree with Jefferson that these men were "an assembly of demigods." It is only realistic to recognize that the delegates were mere mortals, albeit with a high degree of education and governmental experience, but limited by the sectional and economic interests of their times and places. It may be important to recall that the delegates were not elected by popular vote, but were named by the state legislatures, and that their deliberations in Philadelphia took place in secrecy without the media publicity of our day. Whatever their strengths or weaknesses, they succeeded within a space of 4 months in producing a document which has provided a stable government for an expanding nation. Its endurance for 200 years with very few formal amendments, but with many interpretations to meet changing conditions, is a record for a republican form of government.

**T**he basic challenge facing the delegates was to devise a form of government strong enough to govern effectively at home and to win respect in the world of nations, yet leaving the states powerful

enough for the new national government to be acceptable to them. This was accomplished by means of judicious compromises reached after long and strenuous debate and much changing of minds. It is this aspect of the work of the framers which appears to justify the judgment of George Washington that the Constitution was nothing less than a miracle.

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**These conclusions come to have more meaning for us when we recall two basic concepts in the political philosophy of these 18th Century statesmen: that powerful government is a threat to liberty and that the nature of man is such that he cannot be trusted to use power wisely.**

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The determination of the states to retain their power is understandable. From 1776, when independence was declared, until 1781, when the Articles of Confederation were finally adopted, each one of them had been in the unusual position of being an independent sovereign entity. Each one had formulated and adopted a state constitution and had set up its own form of government. Even after the Confederation government had been established, the states dominated the central government which they had created. Such power was not to be relinquished without the greatest resistance.

Virginia sent the most prominent group of delegates to the Philadelphia Convention. Arriving before a quorum of delegates appeared, they worked out a set of resolutions which provided an agenda for the whole body. This was the so-called

Virginia or Large State Plan presented by Governor Edmund Randolph shortly after the Convention had come to order and had elected George Washington as the presiding officer. Although this position prevented his active participation in the business of the Convention, Washington exerted a strong influence through discussions in committee of the whole and through personal contacts. His prestige carried great weight in the ratification conventions.

The central issue in the debates was the relative power between the states and the new central government. Representatives of the large states, such as Virginia and Pennsylvania, argued for representation based upon population. Delegates from the small states, such as Delaware and New Jersey, presented their own plan called the Small State — or the New Jersey Plan. It retained the basic pattern of the Articles of Confederation, that is, with each state having an equal voice. The decision to change to a two house legislative body presented the possibility of a crucial compromise. After a long and heated debate, it was agreed that in a Senate or upper house, each state should have equal representation; while in a lower house, the number of representatives should be allotted to states on the basis of population. The more conservative Senate would have its members elected for longer terms by state legislatures; while the popular branch, whose members would be elected every 2 years by voters whose qualifications would be determined by the states, would originate all money bills. This Great Compromise is often called the Connecticut Compromise because it was effected largely by the skill of Roger Sherman and his colleagues from that state. Its adoption saved the Constitutional Convention.

Compromises were also worked out on other controversial issues. In determining the number of Congressmen for each state in the House of Representatives, the slave states sought to have the total num-



ber of slaves counted in the population, but they opposed having them counted for purposes of apportioning direct taxes. Nonslave holding states opposed counting slaves at all. Finally it was agreed to continue to use the federal ratio which had been used in the Confederation: slaves would be counted as three-fifths in the total. Planter interests won a point when it was agreed that no taxes could be levied on exports. Slave owners also secured agreement that the slave trade could be continued for 20 years until 1808 without interference from Congress. The question of the abolition of slavery was not discussed seriously at all.

Arguments were presented for a plural executive elected by the Congress or for a single executive to serve for life without compensation. Finally, however, agreement was reached to lodge the executive power in a single salaried executive to be elected by an electoral college with no limitation on the number of 4-year terms he might serve.

These conclusions come to have more meaning for us when we recall two basic concepts in the political philosophy of these 18th Century statesmen: (1) that powerful government is a threat to liberty, and (2) that the nature of man is such that he cannot be trusted to use power wisely. They feared the possibility of exchanging the tyranny of George III for that of a powerful central government. In their efforts to protect those liberties won at such sacrifice during the Revolution, they adopted the philosophy of the Frenchman, Montesquieu: the separation of powers. They divided the enumerated powers of the new government into Legislative, Executive, and Judicial; however, they devised a system of checks and balances to restrain the powers of their new creature. By this means, they sought to prevent the abuse of power at the expense of liberty. They also feared the tyranny of the majority and were skeptical of democracy, restricting the exercise of the popular will only to the election of representatives to the lower house in the Congress.

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**Present day critics center their condemnation of the framers around their failure to abolish slavery and to enfranchise women. . . . They . . . fail to give credit for wisdom to the framers who chose to restrict themselves to writing a brief constitution of governmental principles, rather than proposing a collection of laws designed to correct the ills of that day.**

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**W**hen the work of the delegates approached its end, a committee on style was appointed to put the agreements into final form. Gouverneur Morris of Pennsylvania is credited with being the principal stylist. His words were simple and clear; but his use of the phrase, "We the people of the United States," to open the preamble was a stroke of genius. Opponents of the document charged that there was no authority for such a concept, there being only "people of each state," but the phrase was retained. It is not only simple but has served as an eloquent ideal for the evolving nation ever since. On September 17, 1787, 39 of the 55 members signed the document, which Washington, as President, transmitted to the Congress of the Confederation, with the recommendation that it be sent to the states for approval by specially elected conventions. The delegates had already exceeded their authority by writing a new constitution instead of merely amending the Articles. Now they went further

by providing that their handiwork should go into effect after nine, instead of all 13, states had ratified it.

The ratification process began promptly, with the result that three states had indicated their approval before the end of 1787. Georgia was the fourth to approve, and without a dissenting vote. By the summer of 1788, eight states had given their assent before the Virginia Convention met to cast what would be a crucial vote. Opposition to ratification in that state was strong because Patrick Henry, George Mason, Richard Henry Lee, and other original revolutionists insisted that a Bill of Rights be incorporated *before* final approval was voted. After a spirited debate, Virginia finally approved the document as presented by the close vote of 89 to 79. The amendments which had been debated were passed on to the Congress, with the insistence that they be added to the Constitution. By this time, New Hampshire had ratified as the ninth state, thus putting the document into effect.

New York, where opposition was as strong as that in Virginia, was swept along in the tide of approval. The Convention accepted the document by the close vote of 30 to 27. Much credit for that close but crucial victory goes to Alexander Hamilton who initiated a series of newspaper articles written by himself, James Madison, and John Jay, setting forth the merits of the proposed document. Collected later and published under the title of *The Federalist Papers*, they have become a classic of American political theory.

Although neither North Carolina nor Rhode Island had voted approval, machinery was put in motion to set up the government called for by the new Constitution. Members of the new Congress were selected in the states; the Electoral College elected George Washington as the first President by unanimous vote; and when he was inaugurated in New York City on April 30, 1789, the new government was ready to replace the old. North Car-



olina finally joined the new union on November 21, 1789, and Rhode Island, on May 29, 1790. The guarantee of individual liberties which Patrick Henry and others had demanded was added to the Constitution as the first 10 amendments in 1791. They are known as the Bill of Rights.

**P**resent day critics center their condemnation of the framers around their failure to abolish slavery and to enfranchise women. Modern liberals find Jefferson's "assembly of demigods" objectionable as "an overtly racist, slave-

holding or slave-tolerating group of privileged white males." These critics find it difficult to praise as heroes their fellow liberals of 2 centuries ago who sought to protect liberty by restricting the powers of government. They find it equally difficult to admire men who were more concerned to protect liberty than to promote equality. They also fail to give credit for wisdom to the framers who chose to restrict themselves to writing a brief constitution of governmental principles, rather than proposing a collection of laws designed to correct the ills of that day.

In short, critics seem to refuse to place the Constitution in its historic context. Political realities dictated compromises which were necessary to establish that union which has evolved into an instrument for guaranteeing a longer array of liberties than the framers could have envisioned in 1787. As we observe the Bicentennial, let us not worship the framers as gods, but let us give them the credit which they are due. Above all, let us try to understand them in the context of their times.

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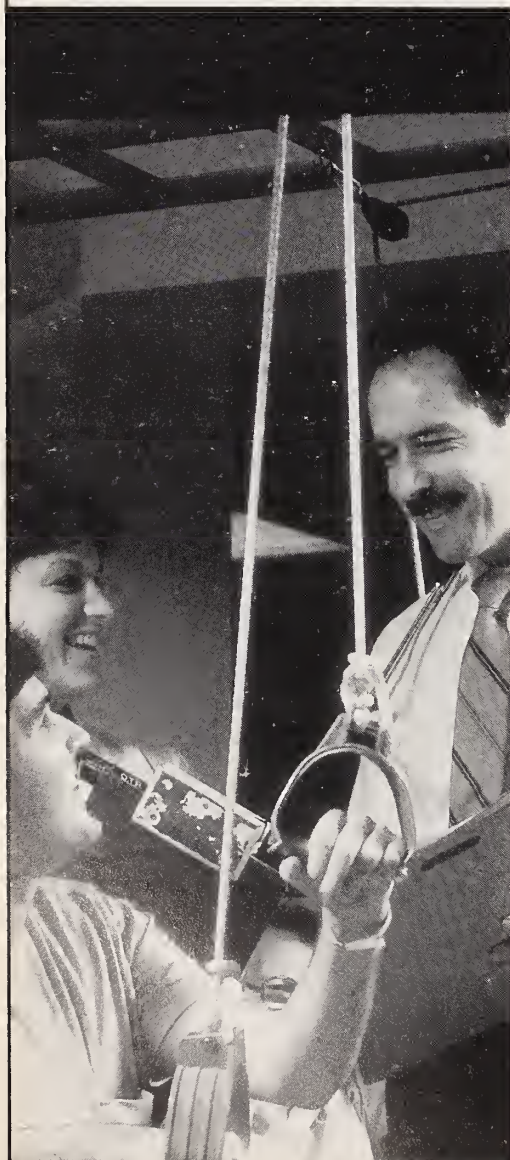
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American Medical Association

# Presidential Candidate Questionnaire

## *Questionnaire on Health and Related Topics*

### Introduction

Earlier this year, the American Medical Association sent a questionnaire to all presidential candidates regarding their opinions on major health issues. Replies were printed in the February 26 issue of *American Medical News*. Presented here are the comments of only Governor Michael Dukakis and Vice President George Bush, the front-runners of their respective parties.

### AIDS

1. *Do you favor testing for AIDS for all citizens?*

**DUKAKIS:** No.

**BUSH:** (Note the candidate presented the following statement in response to Questions 1-6 on AIDS issues.) We must do all we can do to stop the spread of AIDS in this country. We must look for innovative solutions to this staggering problem. But money alone won't stop AIDS. Those at high risk must be educated on how to avoid contracting the disease. The only guaranteed way to halt the spread of AIDS, given what we know now, is a change of behavior.

The issue of testing raises some difficult and troublesome questions for me. It puts in conflict the need for more information and knowledge to benefit the majority versus our basic Constitutional right to privacy. And it is the responsibility of

the political leadership of the country to decide among these competing principles.

Ultimately, we must protect those who do not have the disease. Thus, we have made the decision that there must be more testing. We are encouraging the states to offer routine testing for those who seek marriage licenses and for those who visit sexually transmitted disease or drug abuse clinics. We are also encouraging states to require routine testing in state and local prisons.

Of course, any mention of testing must be hurriedly followed by the word, "confidentiality." If society feels compelled, in some circumstances, to test its citizens, then it is absolutely imperative that those records are kept appropriately confidential. It is also imperative that help be available to those who test positive. We need testing, but only accompanied by guarantees that everyone is treated fairly.

I feel deeply for parents on both sides of this issue. I understand the concerns of parents allowing school age students who either test positive for AIDS virus or who have AIDS to stay in the classroom. Parents have a legitimate right to demand that their children be educated in a healthy environment. At the same time, the parents of children who either have AIDS or who have tested positive for the AIDS virus have a real concern that their children not

be unnecessarily isolated from a normal social setting. Although this is a highly emotional issue, we must make our decisions based on the best current evidence that the medical profession has to offer. Based on what the doctors tell us, I believe that these children should be allowed to stay in the classroom, on the condition that proper safeguards are taken.

2. *Should such testing be voluntary or mandatory?*

**DUKAKIS:** Voluntary. I do not favor AIDS testing for the entire population, only for those who seek it. We should, however, encourage voluntary testing for those in high-risk groups.

**BUSH:** See comment to question #1.

3. *Should there be testing only of specific groups in our society?*

**DUKAKIS:** Yes. I favor mandatory testing only in two cases: in the military and in keeping with the traditional authority of the Immigration and Naturalization Service to test immigrants coming from areas of the world with high incidences of communicable disease. But, even in this latter case, exceptions should be made on humanitarian grounds (i.e., to allow persons with AIDS to come to the United States for treatment, or to visit relatives).



**BUSH:** See comment to question #1.

4. *Do you favor a federal or state standard of confidentiality for individuals presenting themselves for testing and counseling?*

**DUKAKIS:** No response.

**BUSH:** See comment on question #1.

5. *Should school age children who either test positive for AIDS virus or have AIDS be allowed to stay in the classroom if they do not exhibit anti-social behavior such as biting?*

**DUKAKIS:** Yes.

**BUSH:** See comment on question 1.

6. *How would you balance the competing interests of the general population and AIDS victims to protect their respective rights?*

**DUKAKIS:** I do not believe that the interests of the general population and the interests of persons with AIDS are mutually exclusive. It is in everyone's interest that we maintain our constitutional rights by keeping AIDS testing confidential. And as our nation's most serious public health threat, it is in all of our interests to prevent its further spread, find a cure, develop a vaccine, and provide compassionate care for people with AIDS.

**BUSH:** See comment on question #1.

### **Professional Liability Reform**

1. *Do you favor the Federal Government extending financial incentive to states that enact minimum tort reform measures?*

**DUKAKIS:** Although there are provisions of the tax code that I would eventually wish to change, I believe we need a period of stability in the tax system. It is disruptive and burdensome for everyone when there are major changes in the tax code almost every year, as there have been for more than a decade.

However, I favor creation of a national model of liability reform which states should be encouraged

to follow. Uniformity and predictability in these matters will do much to ease many of the problems associated with professional liability.

As Governor, I supported the Massachusetts Medical Malpractice Reform Act of 1986 which set a \$500,000 limit on the amount which a jury can award for non-economic damages, i.e., pain and suffering. This cap is intended to strike a balance between the real needs of an injured patient and the very legitimate problems occurring in the medical community as a result of the increase in the number and size of malpractice claims. The law provides that in extraordinary circumstances, a jury may exceed the \$500,000 limit. There is no limit on the amount recoverable for economic damages.

**BUSH:** Medical care and the availability of necessary pharmaceuticals are threatened by the litigation explosion, particularly in such areas as obstetrics and neurosurgery. Tort reform is urgently needed to address this problem. The states have the primary role in reforming tort law. However, I do favor certain reforms that restore fairness and balance to the nation's tort system. I believe we must consider such important reforms as:

Restoration of fault as the standard of recovery of damages, since liability in the absence of wrongdoing directly contributes to the excessive chilling effect of current tort law; Elimination of the joint and several liability rule under which minimally involved defendants can be forced to pay 100 percent of a plaintiff's claim; and expanded use of alternative dispute mechanisms such as binding arbitration and mediation to encourage early resolution of disputes without burdening the court system.

2. *What is your stand on a uniform federal law on medical malpractice claims?*

**DUKAKIS:** Rising medical malpractice insurance premiums pose a serious threat to both physicians and patients and to the availability of quality, affordable health care.

As I pointed out in my comments on question 11, Massachusetts has enacted medical malpractice reform legislation which caps liability awards for malpractice pain and suffering at \$500,000 and provides graduated limits on attorneys' contingent fees at 40 percent for judgments up to \$150,000 and 25 percent for judgments over \$500,000. These reforms have contributed substantially to stabilizing malpractice insurance premiums, while at the same time, ensuring reasonable compensation to victims and preserving access to our legal system and competent attorneys.

**BUSH:** See comment question #1.

### **Uncompensated Care/ Uninsured Persons**

1. *What expansion, if any, of Medicaid would you support to deal with the issue of uncompensated care?*

**DUKAKIS:** It is high time that all of our citizens had basic health insurance in this country. That would be the most effective way to cover the health costs of those who are currently uninsured.

I have just proposed a plan for universal health care for all the citizens of my state. That plan would require all employers, with some exceptions, to provide basic health insurance for their workers and their dependents. Senator Kennedy has introduced similar legislation in Congress. Although I would propose certain modifications in the Kennedy legislation to address small business concerns, the Kennedy approach is one that I support. It would go a long way to providing basic health security for most Americans. And today, 40 million American citizens have no health insurance of any kind.

**BUSH:** All but 17% of Americans have public or private health insurance to provide for their health care costs. They tend to be employees of small business — where the added cost of providing an employee health plan might ruin the business — costing the employee his job as well. We are looking at measures to resolve this problem.



Another pressing issue is the catastrophic cost of long-term care for chronic illness and disability. One and a half million Americans are in nursing homes; many more are cared for at home. The problem will increase as America ages. I have proposed a program that includes the following points:

We should change the tax code to provide incentives for those who can afford to pay for long-term care using group plan insurance.

We should allow conversion of IRAs, savings accounts and life insurance so people can pay for long-term health care.

For those seniors who cannot afford long-term care insurance, we should change Medicaid requirements that force people to "spend down" their life savings before being eligible for assistance.

We also need to do more to promote the *option* of enrolling in innovative plans such as Health Maintenance Organizations (HMO) and Preferred Provider Organizations (PPO), and to induce competition among health care providers. Efficiencies are possible by making government — as well as private insurers — better consumers, and by creating the right kinds of tax and program incentives for efficient, high-quality health care services.

2. *Would you support legislation to require all employers to provide some minimum level of health insurance benefits to their full and part-time employees?*

**DUKAKIS:** See comment to question #1.

**BUSH:** See comment to question #1.

### Health Policy

1. *Do you agree or disagree that the problems associated with rising medical care costs and difficulties in gaining access to care require resolution through federal planning and federal dollars?*

**DUKAKIS:** Agree. With well crafted policy emphasizing public/private partnerships, I believe that the private sector can do most of the job in providing decent health care for our citizens.

However, serious gaps persist. As I mentioned earlier, I favor Senator Kennedy's bill now in Congress that would make available health care coverage to millions of working Americans who lack coverage of any kind.

Moreover, as President, I would require Medicare to pay for home health care services already covered by law.

Thus, when it comes to the most efficient delivery of health care, I do not subscribe to sweeping theories. Our approach should be pragmatic and compassionate. Although the private sector can do most of the job, we should be prepared to fill in the gaps with private/public partnerships, state spending, and with federal dollars when necessary.

**BUSH:** A Bush Administration will address these problems by controlling costs and providing more comprehensive coverage under Medicare.

Several principles must guide this effort. First, the less that government is involved in the day-to-day administration of health care, the more efficiently it will run — which, of course, means that we should shun the various Democrat health care proposals which would involve government bureaucrats in people's personal health care decisions. Second, more efficient administration of health care must be encouraged — and, in particular, the government health programs such as Medicaid and Medicare should not fund waste and inefficiency. And third, we must limit the incentives and ability for patients to file frivolous malpractice suits which drive health care costs up for all Americans. ■

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# Suggested Guidelines for Hospital Privileges in Ventilator Management

**V**ENTILATOR MANAGEMENT is a specialized form of respiratory care requiring a physician to have expertise in multiple disciplines. These include respiratory physiology and pathophysiology, pharmacology, the principles of respiratory therapy, an understanding of the underlying conditions which may produce the need for ventilatory support, of the economic and cost aspects of ventilatory support and of legal and ethical issues surrounding the utilization of respiratory care. Such expertise requires specialized training, frequent updating of technique, and continuous application of acquired skills. Inadequate training or suboptimal management may lead to unduly prolonged ventilator time, unnecessary expense, ventilator accidents or complications, and misallocation of intensive care resources.

Ventilator management should be a designated privilege granted only to those physicians with appropriate training and skills, as in the case for cardiac catheterization, hemodialysis, and other highly specialized procedures.

**T**he Georgia Thoracic Society recommends the following guidelines for the privileging of physicians in hospital ventilator management:

## **Category 1**

Physicians whose specialty training and board eligibility includes or

requires competence in ventilator management and respiratory therapy techniques, including pulmonary internists, anesthesiologists, intensivists, thoracic surgeons, and pediatric pulmonologists or neonatologists. Privileging of Category 1 physicians requires documentation of board certification. Privileges under Category 1 may be granted to physicians who will complete the appropriate board exam within a period of 3 years from date of application.

## **Category 2**

Physicians whose board eligibility or certification does not specifically require competence in ventilator management, but who may in the course of their practice be called upon to carry out primary management of ventilator-dependent patients. Category 2 physicians include general internists and other medical subspecialists, general surgeons and neurosurgeons, and pediatricians. Privileging of Category 2 physicians requires documentation of in-service training or continuing medical education in ventilator management and letters of recommendation specifically outlining ventilator management skills from director(s) of that physician's training experience.

## **Category 3**

Physicians lacking formal pulmonary, anesthesia, or critical care

training who would not ordinarily be called upon to manage ventilator-dependent patients, not described by Categories 1 or 2 above, but who wish to include ventilator management in their clinical skills. Privileging Category 3 physicians requires documentation of competence in ventilator management based on letter of reference from training program directors specifically describing the number and nature of documented ventilator management cases and the specific skills and modalities utilized.

## **Category 4**

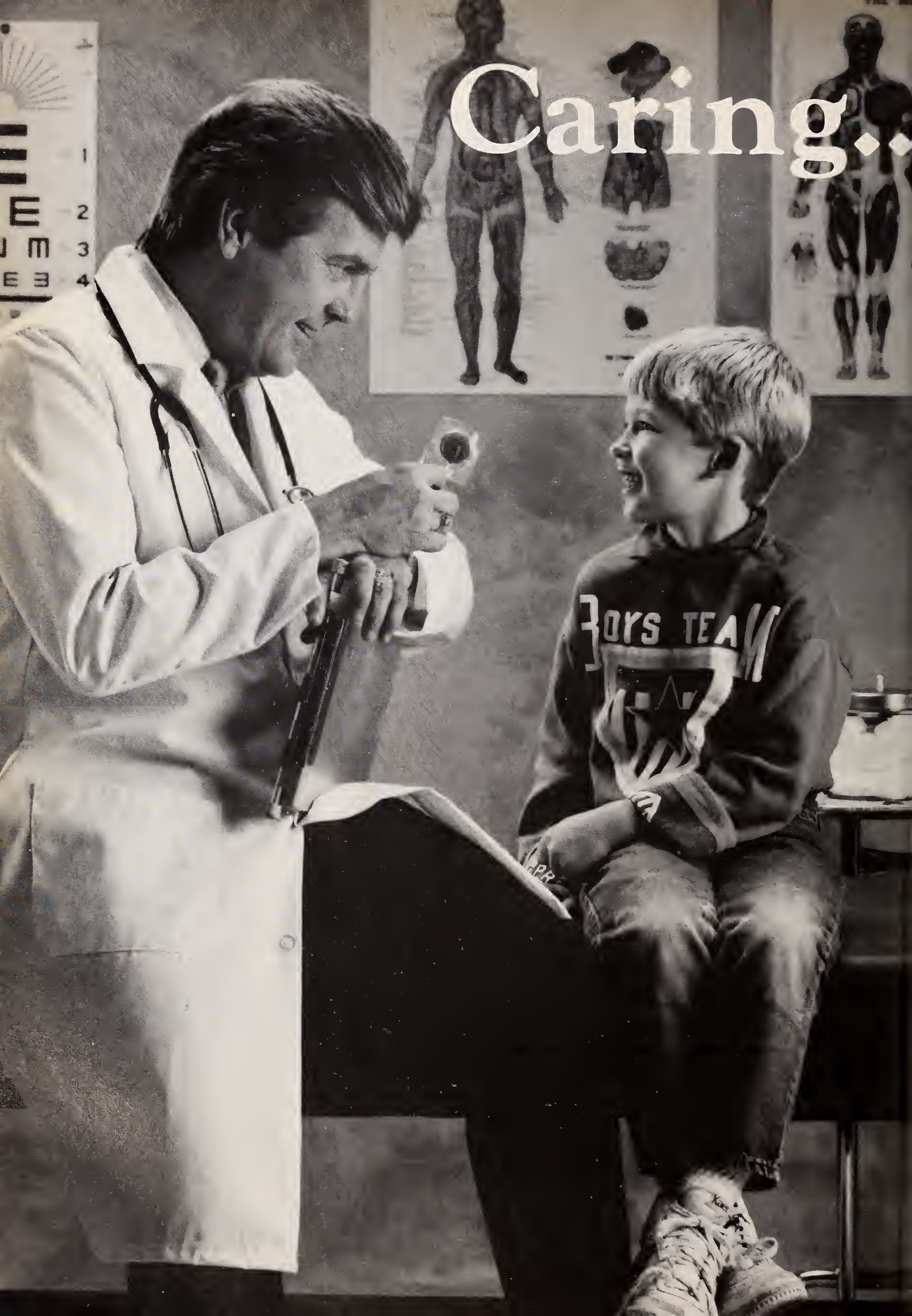
Physicians not described by Categories 1, 2, or 3 who currently hold ventilator privileges may continue to do so after audit of their ventilator management cases by the medical director of respiratory care, chief or staff, or medical director of the local hospital credentials committee.

**A**ll ventilator privileges should be subject to review by the hospital credentials committee at specified intervals with documentation of continued competence and continuing postgraduate education.

These recommendations are intended as guidelines for the privileging of physicians in ventilator management and may be waived, increased, or decreased at the discretion of the credentialing bodies of each institution.



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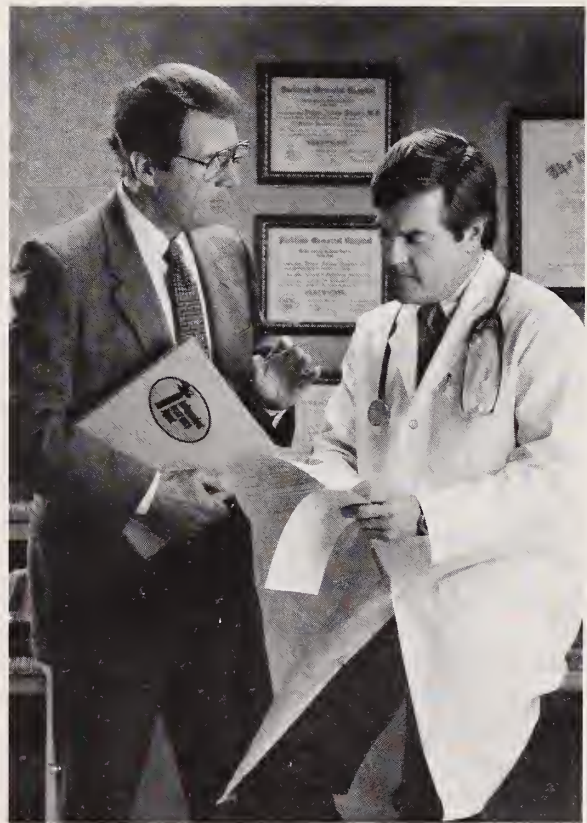
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## Familial Polyposis Coli and the Role of the Polyposis Registry

Vendie H. Hooks, III, M.D., Patty M. Winters, C.T.R., Carole M. Ehleben, M.S.

### Definition of Polyposis

**T**HE TERM "POLYP" may be defined as a circumscribed protrusion above surrounding mucous membrane. Strictly speaking, the word implies the presence of a stalk, but custom has extended its meaning to include flat or sessile lesions as well.<sup>1</sup>

The term "polyposis" includes all varieties of gastrointestinal polyposis (Table 1); however, it has been used more specifically to refer to familial (adenomatous) polyposis coli.<sup>2</sup> An arbitrary minimum of 100 adenomatous polyps has been set as the requirement for a diagnosis of familial polyposis coli.<sup>3</sup> Most patients, however, present with greater than 150 lesions, with the average case having about 1,000 adenomas.<sup>3</sup> Patients with fewer than 100 polyps, but more than 20 polyps, are referred to simply as having "multiple polyposis."

While the presence of numerous adenomatous polyps involving the colon and rectum is common to all patients with familial polyposis coli, a wide array of extracolonic

manifestations may also occur (Table 2). In fact, there is support for the concept that extracolonic expression is the rule rather than the exception. Gardner was the first to recognize the association between familial polyposis coli and extracolonic lesions (i.e., epidermoid cysts, osteomas, and fibromas).<sup>4</sup> Today, familial polyposis coli in combination with any of the known extracolonic findings is

sometimes known as Gardner's syndrome. Perhaps familial polyposis coli, *with or without* additional manifestations, should be termed "Gardner's disease" in a manner analogous to Crohn's disease. After all, familial polyposis coli presents spontaneously, and is therefore not "familial" in up to 1/3 of cases. As in the "inherited" variety, inheritance is autosomal dominant (i.e., 50% of the

TABLE 1 — A Classification of Gastrointestinal Polyps

Type	Solitary	Multiple
<b>Neoplasms</b>		
<b>Epithelial</b>	Tubular adenoma (adenomatous polyp) Tubulovillous adenoma (mixed) Villous adenoma (papilloma)	Familial adenomatous polyposis coli (inc. Gardner's and Turcot's)
<b>Non-epithelial</b>	Lipoma, neurofibroma, hemangioma, leiomyoma	
<b>Hamartomas</b>	Juvenile (mucous or retention) polyp Peutz-Jeghers polyp Cowden polyp	Familial juvenile polyposis coli Peutz-Jeghers syndrome Multiple hamartoma syndrome (Cowden disease)
<b>Inflammatory</b>	Pseudo-polyp Lymphoid polyp	Ulcerative colitis — Crohn's disease Benign lymphoid polyposis
<b>Unclassified (Uncertain)</b>	Mucosal polypoid hypertrophy Metaplastic (hyperplastic or excrescence) ? Cystic pneumatosis intestinalis	Cronkhite-Canada syndrome Multiple metaplastic polyps ?

(Modified from Morson, 1976)<sup>1</sup>

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offspring should be affected).<sup>5</sup> Almost certainly, as more familial polyposis patients avoid a colorectal cancer death through earlier detection and surgery, the list of observed extracolonic manifestations will grow as will the numbers of patients in whom they appear.

Familial polyposis coli is one of the most premalignant conditions known. Estimates of the proportion of patients with familial polyposis coli is approximately 1/6850 in the United States.<sup>6</sup> This syndrome is unique in that the related cancer most often develops at an especially early age — the majority of cases presenting by age 40.<sup>2</sup> There is also virtual certainty that colorectal cancer will occur in all patients unless surgical intervention takes place.

### Role of the Registry

The key to preventing death from colon and rectal cancer in

**“A registry is intended to educate both patients and physicians, allow for systematic identification of people at risk, and provide a coordinated means for appropriate follow up.”**

**TABLE 2 — Extracolonic Manifestations of Familial Polyposis Coli**

<i>Gardner's Original Syndrome</i>	Osteomas Fibromas Epidermoid cysts
<i>Additional Disorders</i>	
Central Nervous System	Tumors (Turcot's)
Mesenchymal	Desmoid tumors
	Adhesions
	Mesenteric panniculitis
Gastrointestinal	Stomach polyps
	Stomach cancer
	Duodenal polyps
	Small bowel adenomas
	Periampullary cancer
	Acute pancreatitis
	Bile duct cancer
	Gallbladder cancer
Endocrine/Genitourinary	Thyroid cancer
	Adrenal cancer
	Parathyroid adenoma
	Ovarian cyst
	Uterine leiomyoma
	Endometriosis
	Renal cysts
	Ureteral duplication
Maxilla/Mandible	Exostosis
	Odontomas
	Supernumerary teeth
	Multiple dental caries
Miscellaneous	Leukemia
	Lipomas
	Leiomyomas
	Bone sarcoma

patients with familial polyposis coli is the early identification of patients at risk. Polyposis registries can significantly impact on a physician's ability to identify these patients. The registry can serve as a detective and investigative agency through family tracing and investigation of known cases of familial polyposis. More often than not,

these efforts lead to further identification of persons who had been unaware that they were at risk. As previously noted, half the offspring of familial polyposis patients are at risk for the development of the disease. This high risk factor emphasizes the tremendous need for surveillance to be as consistent and comprehensive as possible.

Not only is a polyposis registry important from an identification standpoint, but it also helps physicians and patients alike with regard to lifelong surveillance, both before and after surgery. Having recognized this, St. Marks Hospital, London, established the first polyposis registry in 1925. Currently, there are at least 15 registries in operation throughout the world. It has been shown that the percentage of patients already having undetected colorectal cancer can be reduced from 50 percent to 6 percent by the investigation of asymptomatic family members at risk for familial polyposis.<sup>7</sup>

A registry is intended to educate both patients and physicians, allow for systematic identification of people at risk, and provide a coordinated means for appropriate follow up. A regional registry can, in addition, participate with registries from other regions of the country in cooperative projects. Information thereby obtained may help fill in gaps in our knowledge and experience regarding polyposis and, hopefully, allow us to improve our understanding of colorectal cancer.

### At-Risk Screening

A thorough evaluation of family members of a patient with polyposis coli is imperative. However, since the polyps do not usually arise in the large bowel until puberty,<sup>8</sup> children generally need not be evaluated until the age of 10. The evaluation should consist of yearly sigmoidoscopy and fecal occult blood testing. If rectal polyps are found or if the fecal occult blood tests are positive, then colonoscopy is indicated. Two or three adenomas in a young child in an affected family are sufficient to make the

**‘It is of clinical significance that the average interval between diagnosis of colonic polyposis and periampullary malignancy has been reported to be 15 years.’**

diagnosis of polyposis coli. Should epidermal cysts occur prior to puberty, polyposis coli should be suspected. The panoramic x-ray has been reported to have a significant correlation with polyposis and may have a role in screening family members.<sup>9</sup>

### Extracolonic Malignancy

Of the extracolonic gastrointestinal malignancies in familial polyposis coli, periampullary cancer is the most common, with over 30 reports in the literature. It is of clinical significance that the average interval between diagnosis of colonic polyposis and periampullary malignancy has been reported to be 15 years.<sup>10</sup> Although duodenal polyps are quite common (up to 50 percent) and often adenomas, they are usually asymptomatic. However, there is suggestive evidence that duodenal polyps increase the risk for periampullary cancer.

Polyps involving the stomach and/or duodenum have been reported in 64 to 90 percent of patients with polyposis coli who have undergone UGI endoscopy.<sup>11</sup> Histologic examination reveals these gastric polyps to be either (non-neoplastic) fundic gland polyps (25-45 percent) or gastric adenomas (9-44 percent). Twelve

cases of gastric cancer have been reported in the literature.<sup>12</sup> Interestingly, eight of the 12 cases of gastric cancer were Japanese. Quite possibly this reflects the already increased incidence of gastric cancer in that country.

Although it has become obvious that a careful assessment of the upper gastrointestinal tract is necessary with familial polyposis coli, the role of surgical intervention is not yet well-defined. UGI endoscopy with biopsies should probably be performed every 3 years. Symptomatic benign lesions should be resected locally if possible. Pancreaticoduodenectomy and total gastrectomy may be indicated for malignancy, but there is little if any justification for their prophylactic use.

The association of brain tumors with familial polyposis coli has been referred to as Turcot's syndrome. Clinical symptoms most often arise in the second decade of life with neurologic manifestations of brain tumor or chronic diarrhea resulting from the polyps.<sup>13</sup> It is not clear whether this syndrome represents a true separate entity or is once again part of the overall picture of familial polyposis coli. Other possible associated malignancies outside the gastrointestinal tract include papillary carcinoma of the thyroid, adrenal cancer, bone sarcoma, and leukemia.

### Desmoid Tumors

The desmoid tumor was described by John Macfarlane nearly 150 years ago.<sup>14</sup> Its name is derived from the Greek "desmos" meaning band or tendon-like.<sup>15</sup> Desmoids are benign, locally invasive, and recurrent neoplasms affecting the musculoaponeurotic tissue of the body.<sup>16</sup> The tumors



consist of interwoven bundles of spindle cells infiltrating the surrounding muscle with occasional formation of sarcolemmal giant cells. The invasion of surrounding structures (particularly muscle), the absence of a pseudocapsule, the lack of metastases, and the presence of only normal mitoses all serve to distinguish desmoid tumors from fibrosarcomas. Desmoid tumors almost never transform into fibrosarcomas.<sup>17</sup> The reported incidence of desmoid tumors with polyposis coli ranges from 4 to 9 percent, predominates in women (ratio 3:1), and presents in relatively young patients (mean age 29.8 years).<sup>16</sup>

The management of desmoid tumors is a particularly vexing problem, and in some polyposis series they rank as one of the most frequent causes of death. Treatment of patients with abdominal wall or extra-abdominal desmoids should probably be by excision. However, the desmoids in familial polyposis coli are most often mesenteric. Surgery in this instance is extremely difficult, associated with high morbidity, and is usually followed by early recurrence.<sup>16</sup> Furthermore, the sacrifice of excessive small bowel can lead to short gut syndrome with all of its inherent problems. Such morbidity is unacceptable in view of the likelihood of recurrence. Surgery for intra-abdominal desmoids should be reserved for specific indications, such as the relief of intestinal or ureteric obstruction.

Non-surgical treatments of desmoid tumors have had varying degrees of success. Mesenteric desmoids, as is the rule in familial polyposis coli, are relatively insensitive to radiation therapy.<sup>16</sup> Furthermore, heavy

exposure of a wide area including the small bowel would be necessary to induce tumor shrinkage.<sup>18</sup> Most reports of success with radiation therapy usually pertain to non-mesenteric desmoids.<sup>16</sup>

Although there has been isolated success reported with the use of chemotherapy, no large series supports the use of this treatment modality. However, there is enthusiasm at the present time for hormonal or metabolic manipulation of desmoid tumors. The drugs currently being used include sulindac, tamoxifen, and indomethacin.<sup>16</sup> However, in evaluating all therapy, it should be remembered that spontaneous regression has been reported, and, in fact, the basic biologic characteristics of the tumor may have a greater impact on results than the various treatment modalities chosen.<sup>17</sup>

#### Treatment Considerations

Surgery is unquestionably the treatment for familial polyposis coli. The controversy arises over whether to remove the rectum (or its mucosa). Although total proctocolectomy eliminates the

**“It is becoming more evident that patients with polyposis coli are not necessarily cured even after extensive colorectal surgery.”**

colorectal cancer risk, the patient is left with a permanent stoma. Understandably, colectomy with ileorectal or mucosal proctectomy and ileoanal (with a neorectum) have become increasingly popular. Further refinements in

the Kock pouch make this a viable option as well.

On the other hand, it is becoming more evident that patients with polyposis coli are not necessarily “cured” even after extensive colorectal surgery. As has been discussed earlier in this article, even after surgery the risk of extracolonic malignancy still exists and there remains a need for adequate and continual patient follow up. When considering familial polyposis coli, it should be remembered that although the syndrome is relatively rare in comparison with colorectal cancer, the absolute number of people potentially at risk is far greater than the number who will eventually develop cancer. This in itself presents problems for individual physicians in trying to identify cases and provide adequate surveillance.

**T**he familial polyposis registry is the most efficient mechanism available to manage the unique problems associated with this disease. Recognition of this fact led to the establishment of the Southeastern Familial Polyposis Registry, sponsored by the Harry W. Jernigan, Jr. Cancer Center of University Hospital in late 1987 under the direction of the senior author. Although operational for less than a year, the Southeastern Familial Polyposis Registry has identified and is currently following 10 probands and their kindred. Recently, the Registry was invited to join the Leeds-Castle group of international polyposis registries. We are optimistic that the Southeastern Familial Polyposis Registry will significantly impact on the care of patients in the Southeastern United States with familial polyposis coli, a life-threatening disease.



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## Statutory Protection for Peer Review Committees — Can It Be Waived?

Robert N. Berg

**‘... at least to the Court of Appeals, ... actions of peer review committees, hospitals and the committee members themselves, may result in the waiver of the privilege created by the Peer Review Statute, thereby opening up the proceedings and records of peer review committees to the discovery process.’**

**I**N GEORGIA, the proceedings and records of physician peer review organizations<sup>1</sup> and medical review committees<sup>2</sup> are required to be held in confidence and generally are not subject to discovery or introduction into evidence in civil or criminal lawsuits.<sup>3</sup> (For purposes of this article, these statutes are collectively referred to as the “Peer Review Statute.”) Historically, although recognizing that the Peer Review Statute is “in derogation of the general policy in favor of discovery and admissibility of probative evidence . . . [and is] to be narrowly construed,” the Georgia Supreme Court repeatedly has interpreted the Peer Review Statute so as to preserve and protect the confidentiality of proceedings and records of peer review committees.

### Scope of Statutory Protection

For example, in *Eubanks v. Ferrier*,<sup>4</sup> the Court affirmed the issuance of a protective order prohibiting the admission into evidence of a peer review committee report on the grounds that the report was confidential and privileged under the Peer Review Statute — despite the fact that the report had in fact *already been disclosed* to the party seeking to introduce it into evidence, by one or more members of the peer review

committee. Similarly, in *Hollowell v. Jove*,<sup>5</sup> the Court took an expansive view of the scope of “proceedings and records” of peer review committees, finding that term to encompass, among other things, information indicating whether or not committee meetings actually took place and, if so, the identities of persons in attendance at those meetings.

Recently, the Georgia Supreme Court heard oral argument in yet another case involving the Peer Review Statute and, in particular, the question of whether the privileged nature of the peer review committee proceedings and records can be waived.

### Waiver of Statutory Protection?

In *Emory University v. Houston*,<sup>6</sup> a patient sued a physician, his professional group and a hospital, for injuries arising out of eye surgery allegedly performed by the physician on the patient’s wrong eye. Apparently of great significance in this suit were certain investigative reports prepared by three hospital peer review committees which had assessed the care provided by the physician at the hospital, both to the patient and to others.

The defendants opposed the production of these reports, on the grounds that they constituted the proceedings and records of peer review committees and thus were protected from discovery

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under the Peer Review Statute. The patient countered this argument by claiming, among other things, that the hospital and physicians had *waived* the protection under the Peer Review Statute, by discussing the contents and conclusions of the reports with the press. The trial court refused to accept this contention, however, holding that the privileged nature of peer review committee proceedings and records could not be waived.

**O**n appeal, the Georgia Court of Appeals reversed the trial court, finding that the statutory protection afforded to peer review committee proceedings and records can be waived under appropriate circumstances. As stated by the Court, "no reason appears for allowing the creator of the committee to use the positive findings of the committee to its public advantage against the patient while not allowing the injured patient to even review them. The privilege is meant to be a shield, not a sword or weapon of offense."<sup>7</sup>

In the Court of Appeals' view, the privilege granted to peer review committee records and proceedings should be analyzed in the same manner as the privileges provided under other Georgia statutes to accountant/client confidences, attorney/client confidences, psychiatrist/patient confidences, and marital communications. Since all of

these communications may be waived in appropriate circumstances, the Court saw no reason why the privilege provided under the Peer Review Statute should be treated otherwise.

Moreover, the Court noted that the Statute itself provides no sanction for breach of the privilege. To the Court, this indicated that the intent of the Statute was not to prohibit, in all circumstances, the disclosure of confidential peer review records and proceedings. Thus, the Court remanded the case to the trial court, to determine whether the defendants in fact waived the Peer Review Statute privilege, by making public statements concerning the findings of the peer review committees.<sup>8</sup>

### Conclusion

The question presented to the Georgia Supreme Court in the *Emory University* case is an interesting one. The Peer Review Statute itself seems quite clear, in providing, without apparent exception, that the "proceedings and records of [peer review committees] *shall be held in confidence and shall not be subject to discovery* or introduction into evidence in any civil action . . ." (emphasis supplied). Nonetheless, at least to the Court of Appeals, actions taken by those responsible for the actions of peer review committees — hospitals and the committee

members themselves — may result in the waiver of the privilege created by the Peer Review Statute, thereby opening up the proceedings and records of peer review committees to the discovery process.

If the Supreme Court agrees, the heretofore expansive nature of the protection provided by the Peer Review Statute may be substantially limited, as patients, physicians and others seek to obtain information generated or produced by peer review committees, on the basis of claims that the statutory privilege with respect to those proceedings and records has been waived. The success of these claims, in turn, may jeopardize the entire peer review process, as physicians become less likely to exercise the degree of candor necessary for the effective functioning of physician peer review committees.<sup>9</sup>

### Notes

1. See, O.C.G.A. §31-7-131(3).
2. See, O.C.G.A. §31-7-140.
3. See, O.C.G.A. §§31-7-133 and 31-7-143.
4. 245 Ga. 763, 267 S. E. 2d 230 (1980).
5. 247 Ga. 678, 279 S. E. 2d 430 (1981).
6. \_\_\_\_\_ Ga. App. \_\_\_\_\_, 364 S. E. 2d 70 (1987), *rehearing denied* (December 15, 1987), *cert. granted* (February 18, 1988).
7. *Id.*, \_\_\_\_\_ Ga. App. at \_\_\_\_\_.
8. *Id.*, \_\_\_\_\_ Ga. App. at \_\_\_\_\_.
9. The *Emory University* case also involves several other issues of importance with respect to the Peer Review Statute, such as the appropriate definition of a peer review committee covered under the Statute, and the applicability of the Statute to the investigation of intentional wrongdoing by peer review committees. ■

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  - ☐ Wings Over the Nile





# The World's Most Popular K\*

**Slow-K<sup>®</sup>**  
potassium chloride  
slow-release tablets  
8 mEq (600 mg)

It means "dependability" in almost any language

\*Based on worldwide sales data on file, CIBA Pharmaceutical Company.  
Capsule or tablet slow-release potassium chloride preparations should be reserved for patients who cannot tolerate, refuse to take, or have compliance problems with liquid or effervescent potassium preparations because of reports of intestinal and gastric ulceration and bleeding with slow-release KCl preparations.

Before prescribing, please consult Brief Prescribing Information on next page.

C I B A



# The World's Most Popular K

## For good reasons

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- **It's economical**—less expensive than all other leading KCl slow-release supplements on a per tablet cost to the patient<sup>1</sup>



**Slow-K<sup>®</sup>**  
potassium chloride  
slow-release tablets 8 mEq (600 mg)

For patients who can't or won't tolerate liquid KCl.

\*The most common adverse reactions to potassium salts are gastrointestinal side effects.

†Pooled mean serum potassium following oral administration of 30 mEq K-Tab compared to 24 mEq Slow-K in diuretic-treated hypertensives (n = 20) over 8 weeks.

C I B A

**References:** 1. Data on file, CIBA Pharmaceutical Company. 2. Skoutakis VA, Acciardo SR, Wojciechowski NJ, et al: Liquid and solid potassium chloride: Bioavailability and safety. *Pharmacotherapy* 1980;4(6):392-397. 3. Skoutakis VA, Carter CA, Acciardo SR: Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics. *Drug Intell Clin Pharm* 1987;21:436-440.

**Slow-K<sup>®</sup>**  
potassium chloride USP  
Slow-Release Tablets  
8 mEq (600 mg)

**BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE INSERT)**

#### INDICATIONS AND USAGE

**BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.**

1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure; hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function; potassium-losing nephropathy; and certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

#### CONTRAINDICATIONS

Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see OVERDOSAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

#### WARNINGS

**Hyperkalemia** (See OVERDOSAGE).

In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

#### Interaction With Potassium-Sparing Diuretics

Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

#### Gastrointestinal Lesions

Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

#### Metabolic Acidosis

Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

#### PRECAUTIONS

##### General

The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

##### Information for Patients

Physicians should consider reminding the patient of the following:

To take each dose without crushing, chewing, or sucking the tablets.

To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.

To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.

To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

##### Laboratory Tests

Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

##### Drug Interactions

Potassium-sparing diuretics: see WARNINGS.

##### Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in animals have not been performed.

##### Pregnancy Category C

Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

##### Nursing Mothers

The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

#### Pediatric Use

Safety and effectiveness in children have not been established.

#### ADVERSE REACTIONS

One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

#### OVERDOSAGE

The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 ml/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

#### DOSEAGE AND ADMINISTRATION

The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

**Note:** Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

#### HOW SUPPLIED

Tablets—600 mg of potassium chloride (equivalent to 8 mEq) round, buff colored, sugar-coated (imprinted Slow-K)

Bottles of 100 . . . . . NDC 0083-0165-30

Bottles of 1000 . . . . . NDC 0083-0165-40

Consumer Pack—One Unit . . . . . NDC 0083-0165-65

12 Bottles—100 tablets each . . . . . NDC 0083-0165-32

Accu-Pak<sup>®</sup> Unit Dose (Blister pack)

Box of 100 (strips of 10) . . . . . NDC 0083-0165-32

Do not store above 86°F (30°C). Protect from moisture. Protect from light.

Dispense in tight, light-resistant container (USP).

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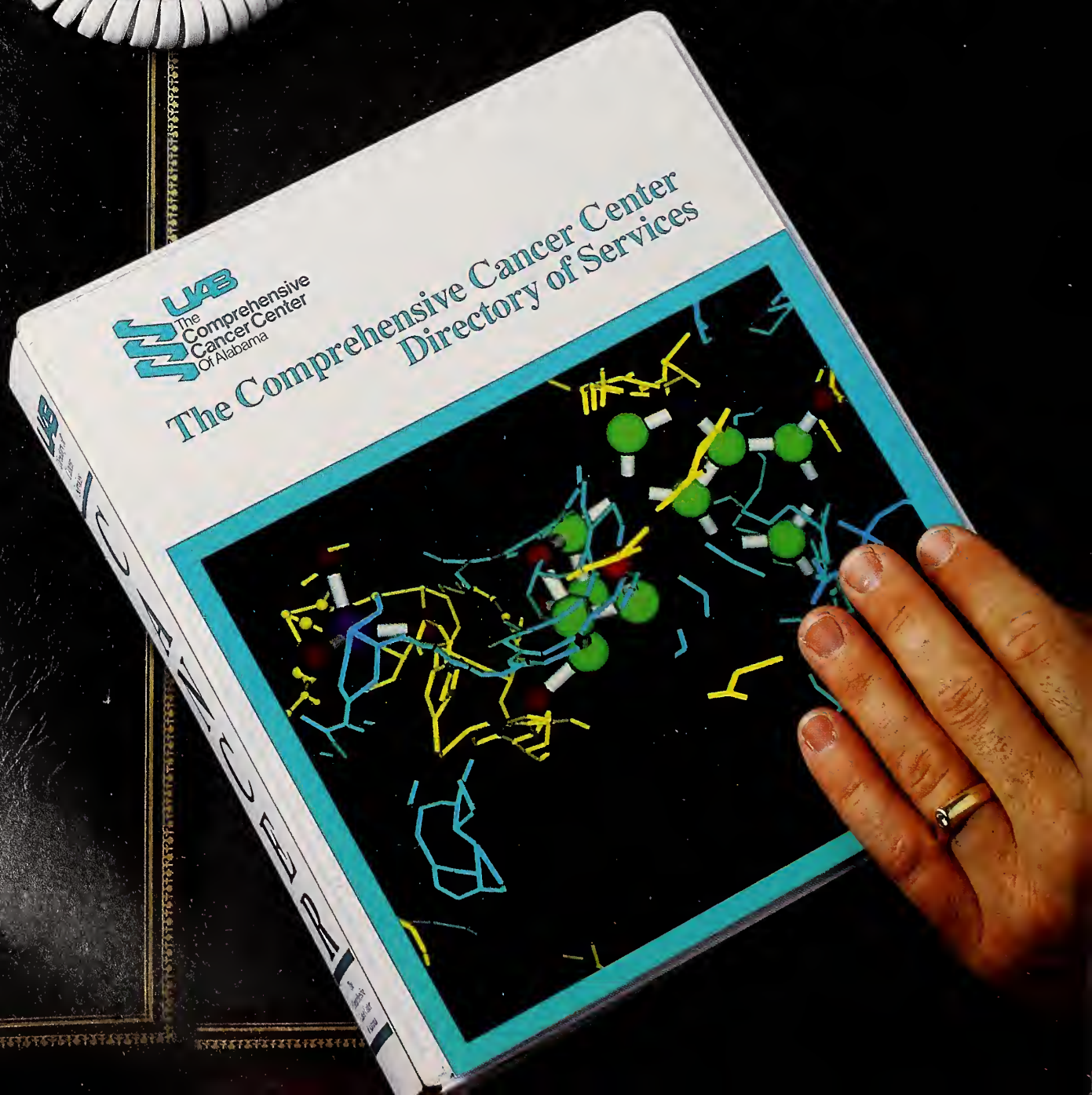
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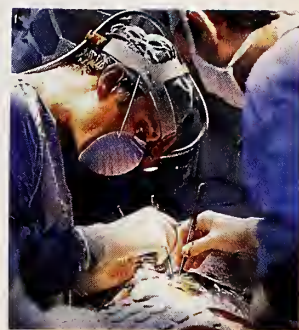


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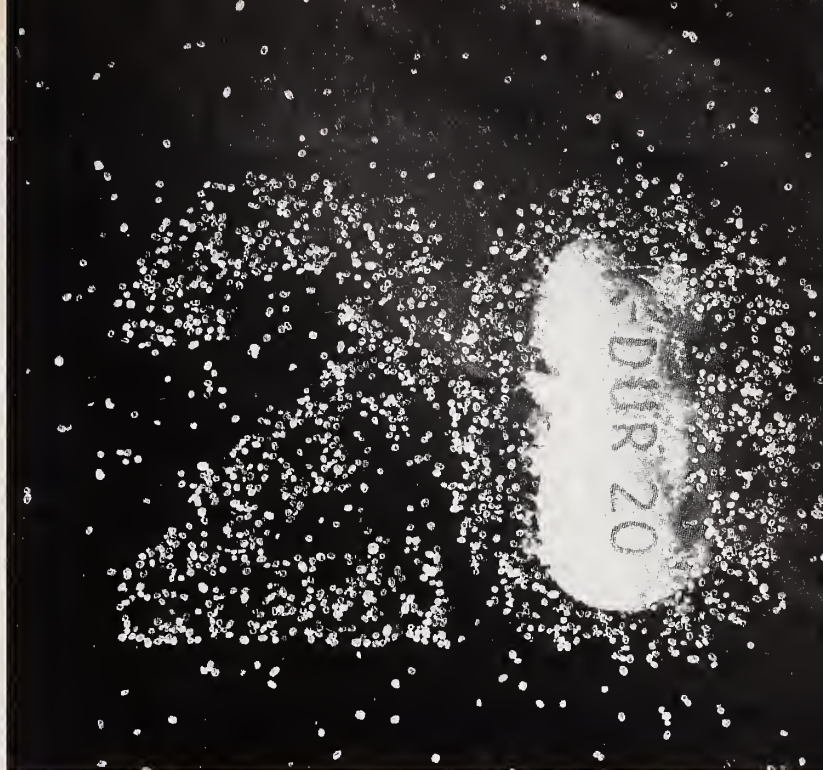
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(potassium chloride) 20mEq Sustained Release  
Tablets

**A daily prophylactic dose  
in a single tablet.**

Please see next page for brief summary of prescribing information.

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# K-DUR<sup>TM</sup> Microburst Release System (potassium chloride) Sustained Release Tablets

**INDICATIONS AND USAGE:** BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.

1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis, in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2. For the prevention of potassium depletion when the dietary intake is inadequate in the following conditions: Patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, and with certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

**CONTRAINDICATIONS:** Potassium supplements are contraindicated in patients with hyperkalemia since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: Chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene).

Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to enlarged left atrium.

All solid dosage forms of potassium chloride supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation.

**WARNINGS: Hyperkalemia**—In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic. The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

**Interaction with Potassium Sparing Diuretics**—Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene) since the simultaneous administration of these agents can produce severe hyperkalemia.

**Gastrointestinal Lesions**—Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage or perforation.

K-DUR tablets contain micro-crystalloids which disperse upon disintegration of the tablet. These micro-crystalloids are formulated to provide a controlled release of potassium chloride. The dispersibility of the micro-crystalloids and the controlled release of ions from them are intended to minimize the possibility of a high local concentration near the gastrointestinal mucosa and the ability of the KCl to cause stenosis or ulceration. Other means of accomplishing this (e.g., incorporation of potassium chloride into a wax matrix) have reduced the frequency of such lesions to less than one per 100,000 patient years (compared to 40-50 per 100,000 patient years with enteric-coated potassium chloride) but have not eliminated them. The frequency of GI lesions with K-DUR tablets is, at present, unknown. K-DUR tablets should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

**Metabolic Acidosis**—Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, potassium acetate, or potassium gluconate.

**PRECAUTIONS:** The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis per se can produce hypokalemia in the absence of a deficit in total body potassium while acute acidosis per se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium. The treatment of potassium depletion, particularly in the presence of cardiac disease, renal disease, or acidosis requires careful attention to acid-base balance and appropriate monitoring of serum electrolytes, the electrocardiogram, and the clinical status of the patient.

**Laboratory Tests:** Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

**Drug Interactions:** Potassium-sparing diuretics: see **WARNINGS**.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** Long-term carcinogenicity studies in animals have not been performed.

**Pregnancy Category C:** Animal reproduction studies have not been conducted with K-DUR. It is also not known whether K-DUR can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. K-DUR should be given to a pregnant woman only if clearly needed.

**Nursing Mothers:** The normal potassium ion content of human milk is about 13 mEq per liter. Since oral potassium becomes part of the body potassium pool, so long as body potassium is not excessive, the contribution of potassium chloride supplementation should have little or no effect on the level in human milk.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS:** One of the most severe adverse effects is hyperkalemia (see **CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE**). There have also been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see **CONTRAINDICATIONS and WARNINGS**); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

**OVERDOSAGE:** The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see **CONTRAINDICATIONS and WARNINGS**). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration and characteristic electrocardiographic changes (peaking of T-waves, loss of P-waves, depression of S-T segment, and prolongation of the QT-interval). Late manifestations include muscle-paralysis and cardiovascular collapse from cardiac arrest.

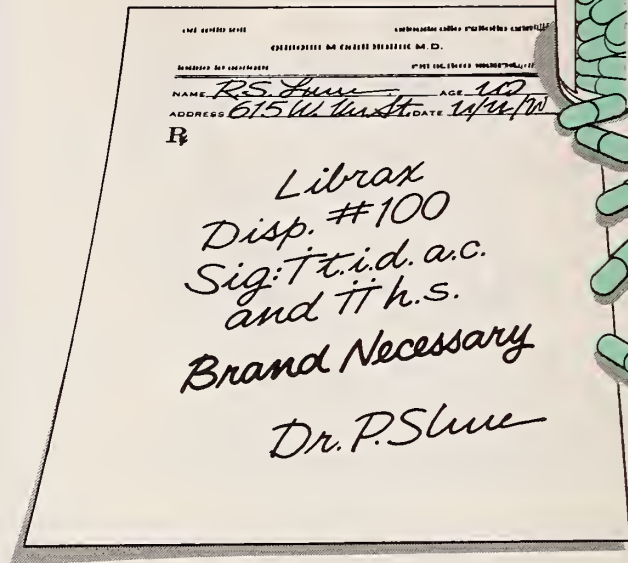
Treatment measures for hyperkalemia include the following:

1. Elimination of foods and medications containing potassium and of potassium-sparing diuretics.
2. Intravenous administration of 300 to 500 ml/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml.
3. Correction of acidosis, if present, with intravenous sodium bicarbonate.
4. Use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia, it should be recalled that in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

Specify Adjunctive.

# LIBRAX<sup>®</sup>



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide.

Please consult complete prescribing information, a summary of which follows:

- \* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows: "Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis. Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br. **Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary.

Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

**Drug Abuse and Dependence:** Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. After extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.



Roche Products

Roche Products Inc.  
Manati, Puerto Rico 00701

P.I. 0288

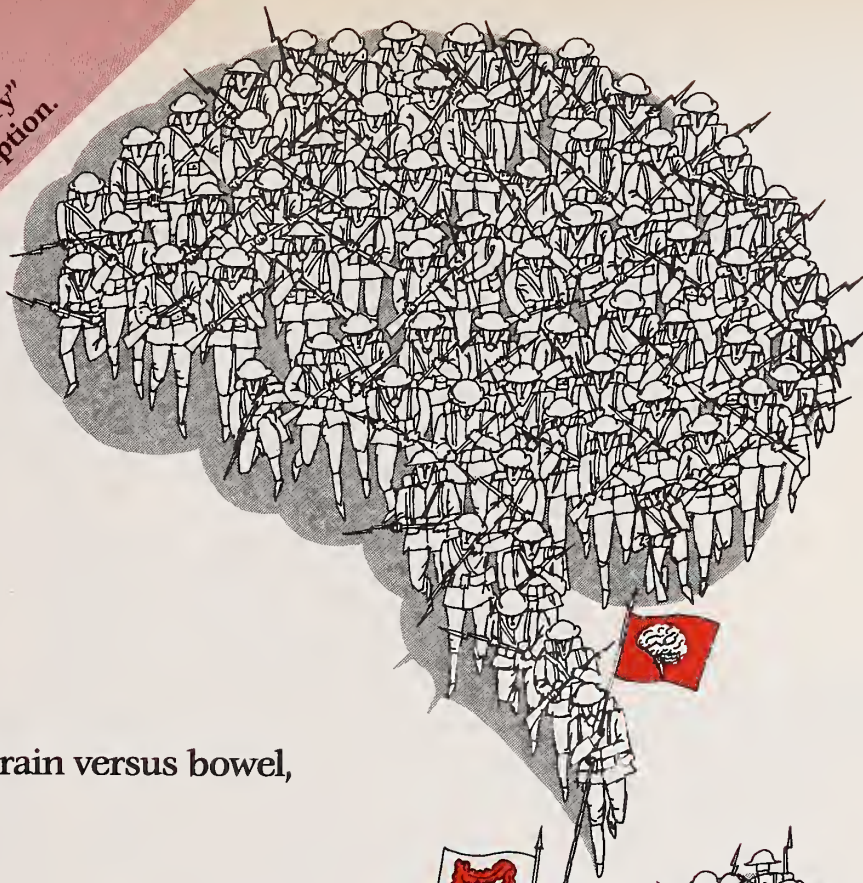
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\*Librax has been evaluated as possibly effective as adjunctive therapy in the treatment of peptic ulcer and IBS.

Specify Adjunctive

## LIBRAX<sup>®</sup>

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HCl and 2.5 mg clidinium bromide.

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**MANUSCRIPTS** — Articles are accepted for publication on the condition that they are contributed solely in this *Journal*. Manuscripts should be typewritten, double-spaced, and the original and one copy should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

**STYLE** — Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the following style: name of author (with initials), title of article, name of periodical, date, volume (number, if available), and pages.

Sorter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. *N Engl J Med* 1976;294:687-90.

**NEWS NOTES** — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

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AUGUST 1988

# JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

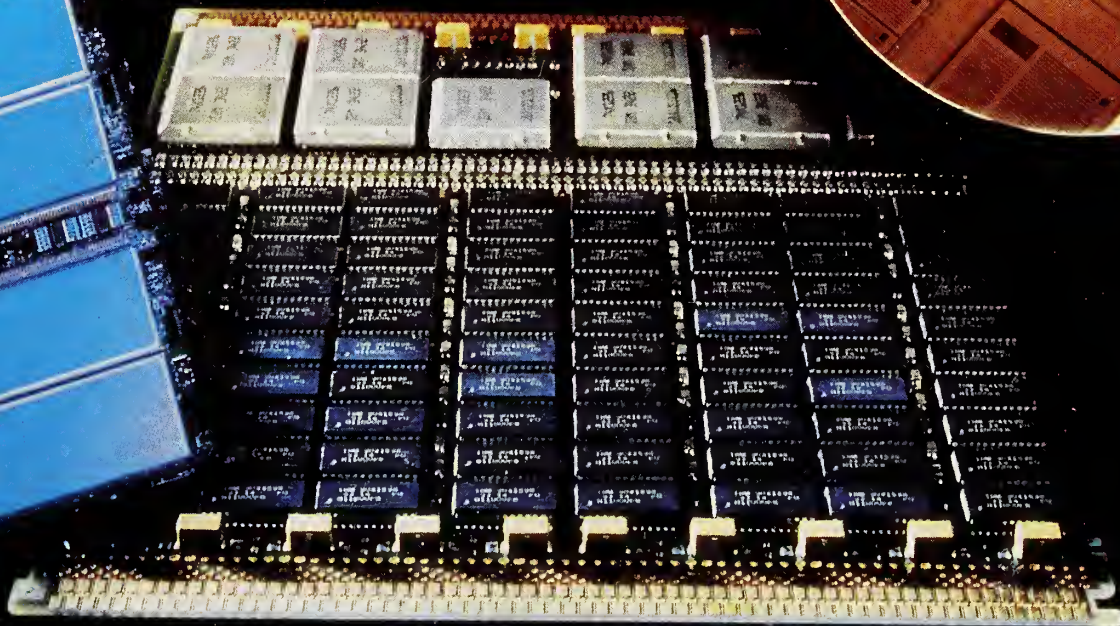
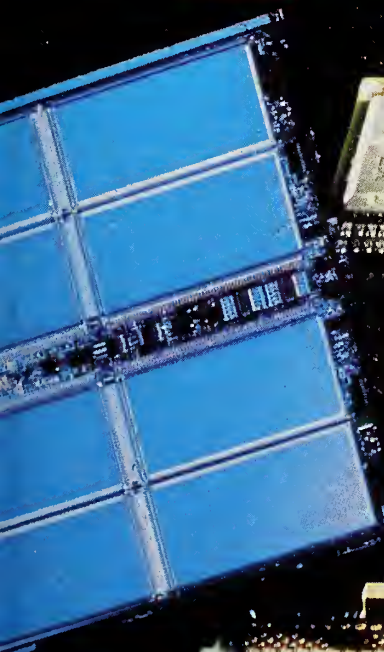
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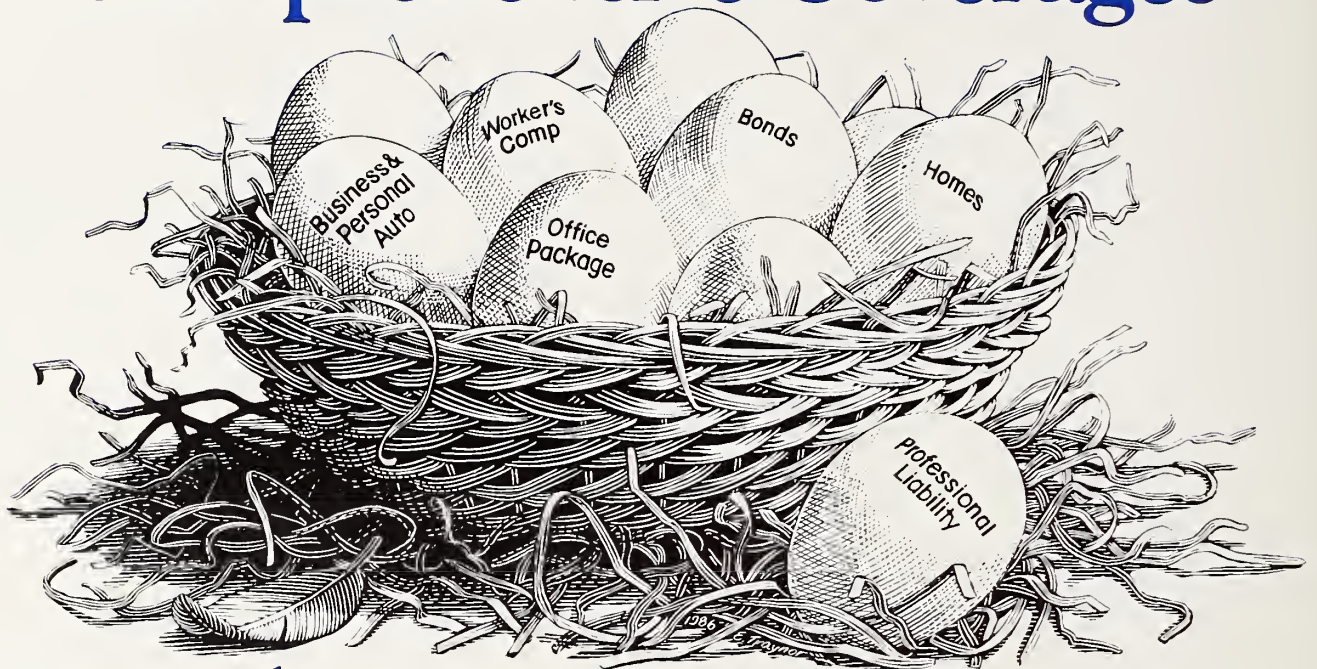
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35-39	\$ 63.00	\$189.00	30-39	\$ 38.00	\$113.00
40-49	\$ 93.00	\$260.00	40-44	\$ 49.00	\$127.00
			45-49	\$ 59.00	\$142.00
50-59	\$148.00	\$370.00	50-54	\$ 70.00	\$155.00
			55-59	\$ 84.00	\$169.00
60-64	\$211.00	\$498.00	60-64	\$101.00	\$186.00

\*The "A + Rated" carrier's premiums would be slightly higher in the Atlanta area. Rates and contracts are subject to change. A number of options are available including Maternity, Prescription, Dental, etc. at additional premiums. All premiums are subject to underwriting acceptance.

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  - lower respiratory tract<sup>†</sup>      –urinary tract<sup>†</sup>
  - skin/skin structure<sup>†</sup>      –bones and joints<sup>†</sup>
- Convenient *B.I.D.* dosage – 250 mg, 500 mg and 750 mg tablets

\**In vitro* activity does not necessarily imply a correlation with *in vivo* results.

<sup>†</sup>Due to susceptible strains of indicated pathogens. See indicated organisms in Brief Summary.

CIPRO® SHOULD NOT BE USED IN CHILDREN OR PREGNANT WOMEN.

A history of hypersensitivity to ciprofloxacin is a contraindication to its use. A history of hypersensitivity to other quinolones may also contraindicate the use of ciprofloxacin.

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Please see adjacent page of this advertisement for Brief Summary of Prescribing Information.

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# Cipro<sup>®</sup> TABLETS (ciprofloxacin HCl/Miles)

■ 500 mg B.I.D. for most infections;  
750 mg B.I.D. for severe or complicated infections.

## BRIEF SUMMARY CONSULT PACKAGE INSERT FOR FULL PRESCRIBING INFORMATION INDICATIONS AND USAGE

Cipro<sup>®</sup> is indicated for the treatment of infections caused by susceptible strains of the designated microorganisms in the conditions listed below:

**Lower Respiratory Infections** caused by *Escherichia coli*, *Klebsiella pneumoniae*, *Enterobacter cloacae*, *Proteus mirabilis*, *Pseudomonas aeruginosa*, *Haemophilus influenzae*, *Haemophilus parainfluenzae*, and *Streptococcus pneumoniae*.

**Skin and Skin Structure Infections** caused by *Escherichia coli*, *Klebsiella pneumoniae*, *Enterobacter cloacae*, *Proteus mirabilis*, *Proteus vulgaris*, *Providencia stuartii*, *Morganella morganii*, *Citrobacter freundii*, *Pseudomonas aeruginosa*, *Staphylococcus aureus* (penicillinase and nonpenicillinase-producing strains), *Staphylococcus epidermidis*, and *Streptococcus pyogenes*.

**Bone and Joint Infections** caused by *Enterobacter cloacae*, *Serratia marcescens*, and *Pseudomonas aeruginosa*.

**Urinary Tract Infections** caused by *Escherichia coli*, *Klebsiella pneumoniae*, *Enterobacter cloacae*, *Serratia marcescens*, *Proteus mirabilis*, *Providencia rettgeri*, *Morganella morganii*, *Citrobacter diversus*, *Citrobacter freundii*, *Pseudomonas aeruginosa*, *Staphylococcus epidermidis*, and *Streptococcus faecalis*.

**Infectious Diarrhea** caused by *Escherichia coli* (enterotoxigenic strains), *Campylobacter jejuni*, *Shigella flexneri*, and *Shigella sonnei*\* when antibacterial therapy is indicated.

\*Efficacy for this organism in this organ system was studied in fewer than 10 infections.

Appropriate culture and susceptibility tests should be performed before treatment in order to isolate and identify organisms causing infection and to determine their susceptibility to ciprofloxacin. Therapy with Cipro<sup>®</sup> may be initiated before results of these tests are known; once results become available appropriate therapy should be continued. As with other drugs, some strains of *Pseudomonas aeruginosa* may develop resistance fairly rapidly during treatment with ciprofloxacin. Culture and susceptibility testing performed periodically during therapy will provide information not only on the therapeutic effect of the antimicrobial agent but also on the possible emergence of bacterial resistance.

### CONTRAINDICATIONS

A history of hypersensitivity to ciprofloxacin is a contraindication to its use. A history of hypersensitivity to other quinolones may also contraindicate the use of ciprofloxacin.

### WARNINGS

CIPROFLOXACIN SHOULD NOT BE USED IN CHILDREN OR PREGNANT WOMEN. The oral administration of ciprofloxacin caused lameness in immature dogs. Histopathological examination of the weight-bearing joints of these dogs revealed permanent lesions of the cartilage. Related drugs such as nalidixic acid, cinoxacin, and norfloxacin also produced erosions of cartilage of weight-bearing joints and other signs of arthropathy in immature animals of various species (SEE ANIMAL PHARMACOLGY SECTION IN FULL PRESCRIBING INFORMATION).

### PRECAUTIONS

#### General:

As with other quinolones, ciprofloxacin may cause central nervous system (CNS) stimulation, which may lead to tremor, restlessness, lightheadedness, confusion, and very rarely to hallucinations or convulsive seizures. Therefore, ciprofloxacin should be used with caution in patients with known or suspected CNS disorders, such as severe cerebral arteriosclerosis or epilepsy, or other factors which predispose to seizures (SEE ADVERSE REACTIONS).

Crystals of ciprofloxacin have been observed rarely in the urine of human subjects but more frequently in the urine of laboratory animals. Crystalluria related to ciprofloxacin has been reported only rarely in man, because human urine is usually acidic. Patients receiving ciprofloxacin should be well hydrated, and alkalinity of the urine should be avoided. The recommended daily dose should not be exceeded. Alteration of the dosage regimen is necessary for patients with impairment of renal function (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION).

#### Drug Interactions:

Concurrent administration of ciprofloxacin with theophylline may lead to elevated plasma concentrations of theophylline and prolongation of its elimination half-life. This may result in increased risk of theophylline-related adverse reactions. If concomitant use cannot be avoided, plasma levels of theophylline should be monitored and dosage adjustments made as appropriate.

Antacids containing magnesium hydroxide or aluminum hydroxide may interfere with the absorption of ciprofloxacin, resulting in serum and urine levels lower than desired; concurrent administration of these agents with ciprofloxacin should be avoided.

Probenecid interferes with the renal tubular secretion of ciprofloxacin and produces an increase in the level of ciprofloxacin in the serum. This should be considered if patients are receiving both drugs concomitantly.

As with other broad-spectrum antibiotics, prolonged use of ciprofloxacin may result in overgrowth of nonsusceptible organisms. Repeated evaluation of the patient's condition and microbial susceptibility testing is essential. If superinfection occurs during therapy, appropriate measures should be taken.

#### Information for Patients:

Patients should be advised that ciprofloxacin may be taken with or without meals. The preferred time of dosing is two hours after a meal. Patients should also be advised to drink fluids liberally and not take antacids containing magnesium or aluminum concomitantly or within two hours after dosing. Ciprofloxacin may cause dizziness or lightheadedness; therefore patients should know how they react to this drug before they operate an automobile or machinery or engage in activities requiring mental alertness or coordination.

#### Carcinogenesis, Mutagenesis, Impairment of Fertility

Eight *in vitro* mutagenicity tests have been conducted with ciprofloxacin and the test results are listed below:

- Salmonella/Microsome Test (Negative)
- E. coli* DNA Repair Assay (Negative)
- Mouse Lymphoma Cell Forward Mutation Assay (Positive)
- Chinese Hamster V<sub>79</sub> Cell HGPRT Test (Negative)
- Syrian Hamster Embryo Cell Transformation Assay (Negative)
- Saccharomyces cerevisiae* Point Mutation Assay (Negative)
- Saccharomyces cerevisiae* Mitotic Crossover and Gene Conversion Assay (Negative)
- Rat Hepatocyte DNA Repair Assay (Positive)

Thus, two of the eight tests were positive, but the following three *in vivo* test systems gave negative results:

- Rat Hepatocyte DNA Repair Assay
- Micronucleus Test (Mice)
- Dominant Lethal Test (Mice)

Long-term carcinogenicity studies in animals have not yet been completed.

#### Pregnancy—Pregnancy Category C:

Reproduction studies have been performed in rats and mice at doses up to six times the usual daily human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ciprofloxacin. In rabbits, as with most antimicrobial agents, ciprofloxacin (30 and 100 mg/kg orally) produced gastrointestinal disturbances resulting in maternal weight loss and an increased incidence of abortion. No teratogenicity was observed at either dose. After intravenous administration, at doses up to 20 mg/kg, no maternal toxicity was produced, and no embryotoxicity or teratogenicity was observed. There are, however, no adequate and well-controlled studies in

## CONVENIENT B.I.D. DOSAGE

### Recommended dosage schedule

Infection Site*	Severity of Infection	Dosage
Respiratory Tract*	Mild/Moderate	500 mg B.I.D.
Bone and Joint*		
Skin/Skin Structure*	Severe/Complicated	750 mg B.I.D.
Urinary Tract*	Mild/Moderate	250 mg B.I.D.
	Severe/Complicated	500 mg B.I.D.
Infectious Diarrhea*	Mild/Moderate/Severe	500 mg B.I.D.

pregnant women. SINCE CIPROFLOXACIN, LIKE OTHER DRUGS IN ITS CLASS, CAUSES ARTHROPATHY IN IMMATURE ANIMALS, IT SHOULD NOT BE USED IN PREGNANT WOMEN (SEE WARNINGS).

#### Nursing Mothers:

It is not known whether ciprofloxacin is excreted in human milk; however, it is known that ciprofloxacin is excreted in the milk of lactating rats and that other drugs of this class are excreted in human milk. Because of this and because of the potential for serious adverse reactions from ciprofloxacin in nursing infants, a decision should be made to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

#### Pediatric Use:

Ciprofloxacin should not be used in children because it causes arthropathy in immature animals (SEE WARNINGS).

### ADVERSE REACTIONS

Ciprofloxacin is generally well tolerated. During clinical investigation, 2,799 patients received 2,868 courses of the drug. Adverse events that were considered likely to be drug related occurred in 7.3% of courses, possibly related in 9.2%, and remotely related in 3.0%. Ciprofloxacin was discontinued because of an adverse event in 3.5% of courses, primarily involving the gastrointestinal system (1.5%), skin (0.6%), and central nervous system (0.4%).

The most frequently reported events, drug related or not, were nausea (5.2%), diarrhea (2.3%), vomiting (2.0%), abdominal pain/discomfort (1.7%), headache (1.2%), restlessness (1.1%), and rash (1.1%).

Additional events that occurred in less than 1% of ciprofloxacin courses are listed below. Those typical of quinolones are italicized.

**GASTROINTESTINAL:** (See above), painful oral mucosa, oral candidiasis, dysphagia, intestinal perforation, gastrointestinal bleeding.

**CENTRAL NERVOUS SYSTEM:** (See above), dizziness, lightheadedness, insomnia, nightmares, hallucinations, manic reaction, irritability, tremor, ataxia, convulsive seizures, lethargy, drowsiness, weakness, malaise, anorexia, phobia, depersonalization, depression, paresthesia.

**SKIN/HYPERSENSITIVITY:** (See above), pruritus, urticaria, photosensitivity, flushing, fever, chills, angioedema, edema of the face, neck, lips, conjunctivae or hands, cutaneous candidiasis, hyperpigmentation, erythema nodosum.

**SPECIAL SENSES:** blurred vision, disturbed vision, (change in color perception, overbrightness of lights, decreased visual acuity, diplopia, eye pain, tinnitus, bad taste.

**MUSCULOSKELETAL:** joint or back pain, joint stiffness, achiness, neck or chest pain, flare-up of gout.

**RENAL/UROGENITAL:** interstitial nephritis, renal failure, polyuria, urinary retention, urethral bleeding, vaginitis, acidosis.

**CARDIOVASCULAR:** palpitations, atrial flutter, ventricular ectopy, syncope, hypertension, angina pectoris, myocardial infarction, cardiopulmonary arrest, cerebral thrombosis.

**RESPIRATORY:** epistaxis, laryngeal or pulmonary edema, hiccup, hemoptysis, dyspnea, bronchospasm, pulmonary embolism.

Most of these events were described as only mild or moderate in severity, abated soon after the drug was discontinued, and required no treatment.

In several instances, nausea, vomiting, tremor, restlessness, agitation, or palpitations were judged by investigators to be related to elevated plasma levels of theophylline possibly as a result of a drug interaction with ciprofloxacin.

**Adverse Laboratory Changes:** Changes in laboratory parameters listed as adverse events without regard to drug relationship:

Hepatic—Elevations of: ALT (SGPT) (1.9%), AST (SGOT) (1.7%), alkaline phosphatase (0.8%), LDH (0.4%), serum bilirubin (0.3%).

Hematology—eosinophilia (0.6%), leukopenia (0.4%), decreased blood platelets (0.1%), elevated blood platelets (0.1%), pancytopenia (0.1%).

Renal—Elevations of: Serum creatinine (1.1%), BUN (0.9%).

CRYSTALLURIA, CYLINDRURIA, AND HEMATURIA HAVE BEEN REPORTED.

Other changes occurring in less than 0.1% of courses were: Elevation of serum gamma-glutamyl transferase, elevation of serum amylase, reduction in blood glucose, elevated uric acid, decrease in hemoglobin, anemia, bleeding diathesis, increase in blood monocytes, and leukocytosis.

### OVERDOSAGE

Information on overdosage in humans is not available. In the event of acute overdosage, the stomach should be emptied by inducing vomiting or by gastric lavage. The patient should be carefully observed and given supportive treatment. Adequate hydration must be maintained. In the event of serious toxic reactions from overdosage, hemodialysis or peritoneal dialysis may aid in the removal of ciprofloxacin from the body, particularly if renal function is compromised.

### DOSAGE AND ADMINISTRATION

The usual adult dosage for patients with urinary tract infections is 250 mg every 12 hours. For patients with complicated infections caused by organisms not highly susceptible, 500 mg may be administered every 12 hours.

Respiratory tract infections, skin and skin structure infections, and bone and joint infections may be treated with 500 mg every 12 hours. For more severe or complicated infections, a dosage of 750 mg may be given every 12 hours.

The recommended dosage for infectious diarrhea is 500 mg every 12 hours.

In patients with renal impairment, some modification of dosage is recommended (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION).

### HOW SUPPLIED

Cipro<sup>®</sup> (ciprofloxacin HCl/Miles) is available as tablets of 250 mg, 500 mg, and 750 mg in bottles of 50, and in Unit-Dose packages of 100 (SEE FULL PRESCRIBING INFORMATION FOR COMPLETE INFORMATION).

\* Due to susceptible strains of indicated pathogens. See indicated organisms in Brief Summary.

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**COVER**

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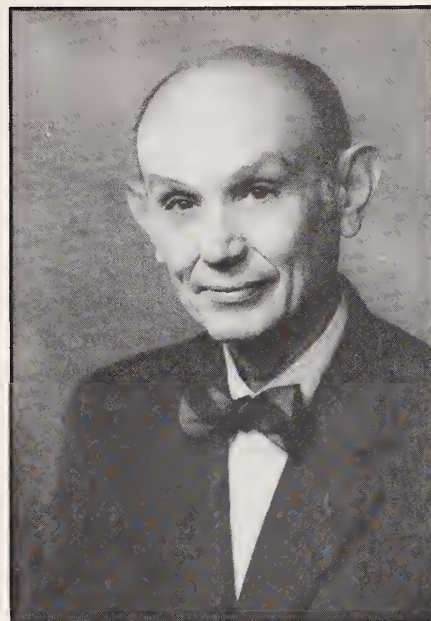
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*Joseph P. Bailey, Jr., M.D.*

**T**HE AMERICAN MEDICAL ASSOCIATION recently completed its 137th Annual Meeting in Chicago. A multitude of important issues were considered. Two that I found of unusual significance were the proposals for trial projects developing registered care technologists (RCT) and an alternative to the civil justice system for resolving medical liability disputes.

**T**he RCT program would train high school graduates in bedside care techniques for a period of up to 18 months. These individuals would be certified or licensed by a state board of medical examiners and function under the supervision of a physician or nurse to augment provision of bedside patient care. Three levels of competence would be recognized: assistant, basic, and advanced. The period of training would be 2, 7, and 9 months, respectively.

In this day of severe nursing shortage and also heavy demand on those nurses we do have, the RCT trial proposal was considered a unique potential solution for the problem. Unfortunately, some of our nursing colleagues viewed it as a negative challenge rather than a positive opportunity.

**T**he AMA alternative liability proposal would provide a patient considering action against a physician the opportunity to directly file a complaint to a medical board, such as the Composite State Board of Medical Examiners in our state. The complaint would be evaluated and a decision made as to its validity, thus avoiding the tort system now in place. The proposed system has the potential of increasing physician exposure to plaintiff claims activity, increasing cost of liability insurance coverage, and still having the tort system in place. Two states, however, reported their opinion as to the potential for reductions in cost of liability coverage with the proposed system. Your Board of Directors voted on June 18, 1988, to advise the AMA delegates to oppose implementation and any AMA support for the proposal.

I urge your consideration of these matters and communication of personal opinions to your county society officers and delegates. The decisions about such issues have long range and definitive import for medicine.

*Joseph P. Bailey, Jr.*

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— MAA — (Resident) 4371  
Winters Chapel Rd., Atlanta  
30360

Wills, S. Angier, Jr., General  
Surgery — MAA — (Resident)  
Emory Univ. Affiliated  
Hospitals, Atlanta 30322

Wiskind, Robert H., Pediatrics —  
MAA — (Resident) 1111  
Clairmont #P-5, Decatur 30030

Wolford, Thomas L., Cardiology  
— MAA — (Resident) 1814  
Brook View, Doraville 30340

## PERSONALS

### *Georgia Medical Society*

**Fremont P. Wirth, M.D.**, a Savannah neurosurgeon, was elected President of the Southern Neurosurgical Society, a 40-year-old organization with some 400 members from 16 southeastern states. It is the third largest neurosurgical organization in the country. Its members are concerned with maintaining quality neurologic surgery through education and research.

### *Gwinnett-Forsyth County Medical Society*

**David A. Bray, M.D.**, an internist, recently opened his practice in Cornelia. He previously practiced in Lawrenceville for 2 years. Dr. Bray will be working in the cardiac rehabilitation program at Habersham County Medical Center. He also became president of the American Heart Association in July.

### *Clayton-Fayette County Medical Society*

**Frank E. Rasler, M.D.**, has joined the staff at HCA Parkway Medical Center. He specializes in emergency medicine.

### *Cobb County Medical Society*

Austell physician **Richard Hammonds, M.D.**, was awarded the third annual South Cobb Citizen of the Year Award last June. The award is co-sponsored by the Austell/South Cobb Division of the Cobb Chamber of Commerce.

Dr. Hammonds has practiced medicine in Austell for 26 years. He was the first chief of staff at Cobb General Hospital, president of the Medical-Dental staff at the hospital, and chairman of the Cobb County Board of Health.

He also was a member of the Georgia state Democratic

Executive Committee for many years and served on the state Prison Parole Board during Carter's term as governor. He was a close friend and advisor to Carter when he reached the White House.

**Rolf Walter Meinhold, M.D.**, a family practitioner, recently joined Dr. John Holcombe's medical practice in the Hiram Professional Building. Dr. Meinhold had previously served at KENMED in Kennesaw.

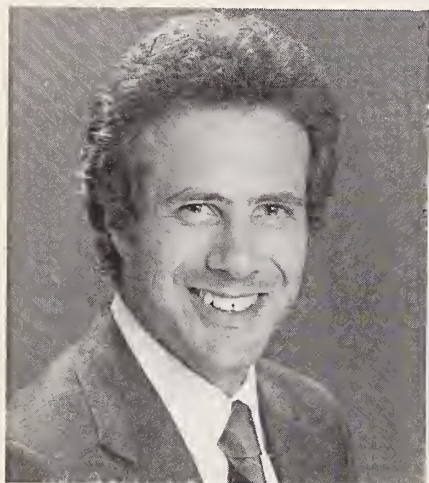
**Imani VanNoy, M.D.**, has opened her office for the practice of internal medicine at Post Oak Professional Center in Marietta. Originally from Albany, Dr. VanNoy attended Harvard Medical School and has been practicing in Cobb County since 1984.

### *Medical Association of Atlanta*

**Rebecca S. Tarlton, M.D.**, a radiologist, has recently joined HCA Parkway Medical Center's Radiation Therapy Department.

A native of Ontario, Canada, Dr. Tarlton graduated with honors from the University of Western Ontario in London, Ontario, where she completed her internship and residency at University Hospital. She completed a second residency in Internal Medicine at the University of Toronto, as well as a fellowship in Radiation Oncology at Princess Margaret Hospital in Toronto. Dr. Tarlton also completed Radiation Oncology fellowship at Duke University Medical Center in Durham, North Carolina. She is also associated with the Emory Clinic, Emory University.

**Saleh A. Zaki, M.D.**, has been appointed chief medical examiner by the Fulton County Board of Commissioners. He joined the medical examiner's staff as a deputy director in 1974.



*Michael Haberman, M.D.*

*Medical Association of Atlanta*  
**Michael A. Haberman, M.D.**, has been certified by the American Psychiatric Association in Administrative Psychiatry. Dr. Haberman is Medical Director of the Department of Psychiatry at West Paces Ferry Hospital in Atlanta. He was previously certified in Clinical Psychiatry and Addictive Disorders.

*Hall County Medical Society*  
**Martin H. Smith, M.D.**, aged 67, retired last May after 37 years of practice as a pediatrician in Gainesville. Smith, a Gainesville native and a graduate of the Emory University School of Medicine, served as president of the American Academy of Pediatrics in 1985-86. He will receive the Grulee Award from the Academy in October for service to pediatrics.

**David Harvey, M.D.**, has been elected vice president of the Georgia Association of County Boards of Health at the annual Georgia Public Health Convention at Jekyll Island.

Dr. Harvey has been a member of the medical staff of Houston County's Medical Center since 1969 and Chairman of Houston County's Board of Health for 12

years. He is also Director of Neonatal Services and Neonatal Intensive Care Unit and medical advisor of the Houston Drug Action Council at the Community Crisis Center.

*Peachbelt County Medical Society*

Three surgeons have recently joined the staff of Taylor Regional Hospital. They are **Virgle McEver, Jr., M.D.**, **Virgle McEver, III, M.D.**, and **George R. Brahn, M.D.**

*Tift County Medical Society*

**Sammie Dixon, M.D.**, 48, chairman of the Tift General Hospital Foundation, was awarded the Governor's Volunteer of the Year Award in Atlanta last April during the Governor's Annual Community Awards Banquet. He is a former chief of staff of Tift General Hospital and a past president of the Tift County Medical Society. He served on the board of directors of the Medical Association of Georgia, representing the Second Medical Society District.

*Troup County Medical Society*

**Richard Simmons, M.D.**, was recently certified by the American Board of Internal Medicine as a specialist in critical care medicine. Dr. Simmons practices with Southern Cardiovascular Associates in LaGrange's Medical Park.

*Ware County Medical Society*

**S. William Clark, III, M.D.**, a board-certified neurologist from Waycross, was elected to a national office in the American Medical Association's young physician section (AMA-YPS) in Chicago last June.

## DEATHS

Former Medical Director of The Georgia Clinic, **Vernelle Fox, M.D.**, died in Claremont, California last May. She had been a resident of California since 1970.

Dr. Fox received her B.S. degree from the University of Tennessee in 1943 and graduated from Tulane School of Medicine in 1947. From 1953-1956, she was in private practice in Atlanta and specialized in psychosomatic illnesses.

She served as Medical Director at the Georgia Clinic from 1956-1969 where her outstanding reputation in the field of alcohol rehabilitation earned her an international reputation. She coordinated a multi-discipline team approach in a therapeutic community setting which was extremely effective in treating alcoholism.

Dr. Fox was a member of the Academy of General Practice and the Fulton County Medical Society where she served on the Committee on Alcoholism. She was on the Board of Directors of the Metro Atlanta commission on Alcoholism and a co-founder and instructor at the Southeast School of Alcohol Studies in Athens, GA. She was a lecturer at Columbia School of Theology and the Candler School of Theology. She wrote a number of publications on alcoholism.

In 1970, Dr. Fox moved to Long Beach, California, where she started an alcohol rehabilitation program at the Long Beach General Hospital. She was medical director of the program. Her last employment was as medical director of an alcohol rehabilitation at Pomona General Hospital in Pomona, California. She had also started this rehabilitation program.

Dr. Fox is survived by two sons.



## ERRATUM

In the June, 1988, Proceedings issue of the *Journal*, the original report of the Ad Hoc Committee on Diversion of Legitimate Prescription Drugs on page 458 was printed in error. The Substitute Report should have been printed, along with the following corrected House Action:

### **Substitute Committee Report AD HOC COMMITTEE ON DIVERSION OF LEGITIMATE PRESCRIPTION DRUGS**

**Milton I. Johnson, Jr.,  
M.D., Chairman**

This Ad Hoc Committee was charged to work with the State Board of Pharmacy, the Georgia Pharmaceutical Association, the Composite State Board of Medical Examiners, and representatives of the Georgia Bureau of Investigation (GBI) to draft model legislation acceptable to all involved groups, to consider solutions to the problem of diversion of legitimate prescription drugs and to insure protection of both the rights of physicians and patients. Our Committee has now completed its charge.

The Committee was reactivated by President Jack F. Menendez during the autumn of 1987 after a request was made by Mr. Michael J. Bowers, Attorney General of Georgia, for MAG's help in what he found to be a continuing severe problem.

The Committee met on October 8, 1987 at which time Attorney

General Bowers, Mr. J. Robert Hamrick, GBI Director, and Mr. James L. Baker, Squad Commander from the Georgia Bureau of Investigation, and Ms. Cheri Baglin, investigator for the Drug Enforcement Administration made presentations concerning the scope of the drug diversion problem.

The Committee considered many facets of the problem and decided to hold an additional meeting for the purpose of hearing from representatives of pharmaceutical manufacturers concerning alternate solutions to the problem other than the "Triplicate Prescription Blank Program." It was also decided to try to rewrite the previously drawn bill, addressing the previously expressed concerns of the Committee, the MAG Board of Directors, prior reference committee and the House of Delegates.

The Committee met again in a lengthy session on December 20, 1987 hearing several presentations in opposition to the Triplicate Prescription Blank Program, and the outlining of possible alternate solutions from three pharmaceutical company representatives led by Mr. Guy Mosier of the E.I. DuPont DeNemours & Company.

The Committee proceeded to rewrite the previously proposed Triplicate Prescription Blank Program bill with advice from MAG General Council, Richard Greene. The provision of the original bill requiring physicians to keep a copy of the prescriptions on file for two (2) years has been replaced with language allowing the physician to merely make a notation of the prescription in the patient's medial record.

The Committee reported to the

February meeting of the Board of Directors at which time Attorney General Bowers discussed the magnitude of the problem of diversion of legitimate prescription drugs in Georgia at considerable length. He asked that MAG sponsor a bill to set up a Triplicate Prescription Blank Program for Class II drugs in Georgia. A lengthy question and answer period followed and, subsequently, the Board voted to refer this proposal to the MAG House of Delegates for further consideration and action.

The Committee feels that it has met its mandate to re-draft the formerly proposed legislation and has attempted to eliminate the major objections expressed by MAG members. The Committee recommends that the House consider a multi-prescription blank program as an appropriate method of addressing the diversion of prescription drugs.

I wish to thank all the members (John A. Manfredi, M.D., Stephen C. May, M.D., Stanley Sherman, M.D., William H. Whaley, M.D.) of the Ad Hoc Committee on Diversion of Legitimate Prescription Drugs for their time and effort to this Committee. Our Committee submits the following recommendations for consideration by the House of Delegates.

#### **Recommendations**

1. That the MAG House of Delegates consider supporting a prescription blank program as an appropriate method of dealing with the diversion of legitimate prescription drugs.
2. That MAG consider endorsing the rewritten version of this bill for legislative action in the 1989 Georgia General Assembly.

## House Action

Adopted the following substitute motion from the floor:  
That the Recommendations of the Report of the Ad Hoc Committee on Diversion of Legitimate Prescription Drugs (Substitute Report) be referred to the Legislative Committee for study concerning impact on current practice after obtaining more accurate data and testimony from states that currently have the laws relating to the subject in effect.

\* \* \*

In addition, the **House Action on Resolution 5 — Diversion of Legitimate Schedule II Narcotic Drugs/Multi-copy Prescription Bill** on p. 465 was printed incorrectly. The correct version is as follows:

*Adopted the House Action of the Ad Hoc Committee on Diversion of Legitimate Prescription Drugs (Substitute Report) as follows:  
That the Recommendations of the Ad Hoc Committee on Diversion of Legitimate Prescription Drugs (Substitute Report) be referred to the Legislative Committee for study concerning impact on current practice after obtaining more accurate data and testimony from states that currently have the laws relating to this subject in effect.*



# Physician's Recognition Award Recipients

LISTED BELOW are those physicians in Georgia who have earned the AMA's Physician's Recognition Award (PRA) from January through June, 1988.

The Award was established by the AMA House of Delegates in 1968 "to recognize, encourage, and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hour of CME must be earned over a 3-year period to qualify for the Award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or cosponsored for Category 1 credit by organizations accredited for these activities.

We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Gabriel Miguel Alfonso,  
Milledgeville  
Earnest C. Atkins, Atlanta  
Ramon Pineda Azahar,  
Milledgeville  
Dwight Lee Bearden, Macon  
Daniel Sender Blumenthal, Atlanta  
Joel Gordon Breman, Atlanta  
Barbara S. Bruner, Atlanta  
Paul Victor Conescu, Decatur

William H. Conner, Rome  
Robert William Crow, Atlanta  
Dave McAlister Davis, Atlanta  
T. Albert Davis, Valdosta  
Ervin Danl. De Loach, Savannah  
Ajita Degala, Macon  
Abelardo R. Delgado,  
Milledgeville  
Lester F. Elliott, Atlanta  
Richard Laurence Elliott, Martinez  
Jos Jacob Ernst, Columbus  
Hossam E. Fadel, Augusta  
Thomas V. Foster, Fortson  
John Askew Fountain, Conyers  
John Edward Fowler, Clayton  
Ronald Allen Freeman, Macon  
Robert Louis Garnett, Columbus  
Kenna Sidney Given, Augusta  
Mark Allen Gould, Smyrna  
William A. Guest, Tifton  
Jefferson D. Hanks, Rome  
Carl Roerig Hartrampf, Atlanta  
Davis Larry Hatmaker, Athens  
James Robert Hattaway, Albany  
Michael Lawrence Hawkins,  
Augusta  
Stephen Michael Herman,  
Savannah  
Raymond Chita Ho, Americus  
Lovic Worth Hobby, Atlanta  
Scott Dewey Holmberg, Atlanta  
Robert Walton Horseman, Evans  
Bruce Wheeler Johnson, Calhoun  
Clarence M. Johnson, St. Simons  
Island  
Julius T. Johnson, Augusta  
Otto Bernice Johnson, Dublin  
Ronald Ivan Kaplan, Marietta  
Kate Killebrew, Atlanta  
Gilbert John Kloster, Atlanta  
Gundy Bellatrix Knos, Chamblee  
Michael Nevins Laslie, Albany  
Dianne Cheryl Leeb, Tucker  
John Grant Lewis, Rome  
Wm. C. Lloyd, Columbus  
Malcom N. Luxenberg, Augusta  
Ahmad Shafik Mahayni, Fitzgerald

Padmanabha Maramreddy,  
Waycross  
Jerome Michael Marchuk,  
Riverdale  
Richard C. Mattison, Atlanta  
Gilbert Orson Maulsby, Columbus  
W. Theron McLarty, Smyrna  
Sylvester McRae, Columbus  
Byron Donald Minor, Decatur  
Chas. Wesley Morgan, Statesboro  
John Charles Munna, Atlanta  
Thomas R. Nolan, East Point  
Alan J. Olansky, Atlanta  
John Theodore Perry, Cartersville  
Sanjeeva Rao, Jackson  
Kothapalli N. Reddy, Americus  
David Paul Rouben, Atlanta  
Lawrence Edward Ruf, Savannah  
Philip Richard Saleeby, Brunswick  
William E. Schatten, Atlanta  
Ronald Oliver Schwartz, Atlanta  
Robt. Saml. Shacklett, Thomaston  
Kamla Jivan Shah, Augusta  
Eloise Baim Sherman, Savannah  
Morton Slutsky, Atlanta  
David Helmar Smith, Savannah  
Larry Ray Smith, Albany  
Dixie E. Snider, Tucker  
Shulin Spektor, Stone Mountain  
Joel David Talley, Stone Mountain  
James Westley Tanner, Lilburn  
Melanie Ann Thompson, Atlanta  
Joel Dennis Todino, Rome  
Richard Andrew Ulrich, Bonaire  
Nirmala Jayarama Upadhyay,  
Dublin  
Mark Lamont Walker, Atlanta  
Robert Michael Warren, Porterdale  
Bruce Stuart Webster, Macon  
Harvey Alan Weiss, Atlanta  
Donald Anderson White, East  
Point  
Lee Talmadge Woodall,  
Barnesville  
Letha Yurko-Griffin, Atlanta  
Vincent N. Zubowicz, Atlanta

## On Cybernetics

***“... hold hands with the keyboard, the CRT, the main frame as we might, there lurks menacingly around the corner the threat that we might shun the challenge of confronting the patient, of using our minds to assimilate and collate and critique the data . . . ”***

**H**OSPITAL ROUNDS were relaxing that December morning, now so far in the past. I had, through years of unrelenting habit, become comfortable with the way my days went. With the methodical sameness with which orders were written, reports returned, and in general with the order and predictability that I had achieved with my way of practicing medicine. I was comfortable until that Sunday morning when I walked to the patient floor to find that our hospital's new computer system had been “brought on line.”

They were gathered about the strangely unfamiliar piece of machinery much as one might have envisioned a group of children catching their first glimpse of a television picture. The ability to simply push a series of keys and have a laboratory test as if by magic spring upon the screen seemed, and was, beyond comprehension. The project of the moment lay not, however, in the realm of scientific inquiry but rather positioned itself among the culinary arts. They were placing the suffering patient's gastronomical requests into the magical maw of the computer terminal. From that huddled mass burst forth the anguish of the one assigned to operate the devilish device. “But she don't want grits t.i.d.!”

Now, the complexities of arranging for the availability at

breakfast time of that regionally honored preparation of boiled, coarsely ground corn meal pales beside that of methodically administering an aminoglycoside every 8 hours. And yet, there dawned upon me that Sunday morning the suggestion that my life, surely my manner of practicing medicine, had been forever changed. Little did I envision the magnitude of that change, for though should I have been able to do so it would have seemed as fanciful and unrealistic as the Lilliputians binding down the Giant Gulliver. But, I would be bound to this technologic giant, for so it was that day, for the remainder of my personal and professional life.

**I**t has been said that man's progress the past few years has surpassed that made by the human race over the previous many centuries. That may be true of the “hardware.” What, though, of the “software” and particularly of the “software” involved in the interaction of the inquiring physician with the physically impaired patient? Have we indeed come to the place in time, or are we relentlessly racing toward it, where the inquiring mind need only to position itself before the “keyboard” — activate in proper sequence the correct keys — and so extract from the impersonal depths of the machine that information so arranged and



interpreted that little be left to accomplish but its transferal to the patient? Can the EKG, the radiographic examination, and the laboratory data be so assimilated that the inquiring mind becomes an outdated piece of "software"? And if so, have we not come precariously close to that point where the physician could be more efficiently — more cost effectively — replaced not by the "nurse practitioner" practicing by protocol but by, let us call him or her, the "interpretative and transmittal practitioner"?

Oh, I think not, but I shudder at the conversation between me and my peers over the past few years. "We can rule out pancreatic cancer. It would have shown up on the CT scan." "We could explore the left side of the neck looking for the parathyroid adenoma, but that will not be necessary. The sonogram on that side is normal." "We had best not operate on her today. The PO<sub>2</sub> is too low (it had found its way to us on the computer screen)." It seems that we are presented each day with a greater challenge to not let become dull that side of our professional lives that asks of us that we maintain the capability of correlating the "hard data" of the IBM with the interpretative ability of the original master computer else we as physicians become as dispensable as though we were last year's Cathode Ray Tube.

**I** still recall with crystal clarity making medical rounds that Saturday morning so many years ago with a group of students, interns, and residents. Paul Beeson, M.D., the quiet and reflective Chairman of the Department of Medicine at Emory, was conducting Grand Rounds. We were talking about a patient in the "colored hospital" at Grady afflicted with some strange malady not lending itself to precise definition. We were in a conference room, the patient still in his bed on the ward. All of the laboratory data were before us. The x-rays were there to correlate with it. We were coming close to putting a name upon the malady from which that patient suffered. And then Paul Beeson suggested that before pronouncing such an obvious conclusion, perhaps we should confront the patient. He said something I have tried assiduously not to forget. He said, "Medicine would be so much easier if one did not have to confront the patient." He was saying to us, at least so it seemed to me, that one must cautiously avoid the seductive tendency to deal only with hard data and ever relentlessly insist upon bringing that data into a correlative relationship, into conflict with, if you will, the fascinating and ever elusive arena of physical diagnosis. Perhaps more than this, he was saying that "the human body has information to

give us that is technologically inaccessible" (George Sheehan, M.D.).

Paul Beeson drifted on out of my life a few months after that remark. Drifted on to positions of prestige at Yale and then at Oxford. The observation hung around me, however, and continues to remind that hold hands with the keyboard, the CRT, the main frame as we might, there lurks menacingly around the corner — in the shadows — the threat. That should we shun the challenge of confronting the patient, of using our minds to assimilate and collate and critique the data, then surely we shall not only have dehumanized medicine but also shall have ushered in the 1984 which George Orwell warned us of and before the prospects of which we can only shudder.

CRU

## *The Impaired Physicians Program: Comments on the Minority Report*

*Marvyn D. Cohen, M.D.*

**I**N A RECENT ISSUE OF JAMA, there was an article on the "Piece of My Mind" page about a doctor who did not know how to get help for a fellow physician who was becoming incapacitated due to an alcohol dependence. The well meaning doctor thought he was doing something constructive by telling his hospital administrator to intervene with this sick doctor. The unfortunate doctor described in the article subsequently committed suicide.

This article was timely for us because at our last annual meeting in Savannah, the Medical Association of Georgia decided to continue the Impaired Physicians Program not only with money but also with participation in the administrative affairs of the program! In the very near future there should not be a doctor in the state of Georgia unaware of the help available for impaired colleagues. Doctors in the larger cities of Georgia have members in their county society who are members of the State Impaired Physicians Committee. Dr. Ed Waits, of Atlanta, is the State Chairman, and there are sub-groups of that committee in Columbus, Macon, Augusta, and Savannah. Each of these medical communities have experienced members to help the impaired

physician and his or her family. This type of support is invaluable to these affected families. There may be some physicians who will seek help outside our state and/or outside the program. This is o.k., as long as some help is provided.

But what about the rural physician who becomes impaired:

1. Will there be a program for that doctor? Who will be the interventionist?
2. Can we be assured of confidentiality if records are kept in an open office in Atlanta?
3. Will the new program director set safeguards to keep our Program strong, self sustaining?
4. Will the oversight committee, currently under the chairmanship of Dr. William Hardcastle (Decatur), maintain a strong presence and give advice and leadership to the ongoing project?

I have written this editorial because, as a delegate from Muscogee County and a member of the Committee F (the House of Delegates) financial oversight Committee, I co-authored a minority report that sponsored this program. Dr. Hardcastle and I personally felt there was a need for this service to our membership. I feel it is as all important to the MAG and Georgia doctors as tort reform, public relations, MAG Mutual Insurance, etc.

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Dr. Cohen practices pediatrics; he served on Reference Committee F at the 1988 MAG House of Delegates. His address is 500 Eighteenth St., Suite B-20, Columbus, GA 31901.



## *Leaving the Landing Lights on for Amelia Earhart*

*Lovick Dickey, M.D.*

**W**HEN THE OWNER of the Washington Redskins was asked why he fired Coach George Allen, he reportedly said, "I gave him an unlimited budget, and he exceeded it."

It is not hard to make such a case for the health care system in this country. It seems to be on a collision course with the American economy. According to figures given in a recent article by Paul A. Bluestein, M.D.,<sup>1</sup> 11½¢ of every dollar is spent on health care, more than one billion dollars per day, increasing 2½ times the rate of inflation. In the U.S. we spend \$2000 a month per capita on health care, but we have the same morbidity and mortality rate as the United Kingdom, which spends \$500 per month, and Singapore, which spends only \$200 a month per capita. Approximately 50% of corporate pretax profits in this country went for health care costs last year.

This is by no means a plea for some other country's system of health care. But some system of rationing, probably *not* decided by physicians, is a reality that looms dead ahead. Daniel Callahan, member of a prestigious think tank, has a current book on

the subject, *Setting Limits*. There can be no painless solution. To think otherwise or to bury our heads in the sand is, as Bluestein says, "like leaving the landing lights on for Amelia Earhart." Cutting out the fat of inefficient tests, unnecessary admissions, services with low returns, etc. are going to be musts. The financial burden of providing all possible care to everyone all the time is meeting increasing resistance. Physicians, nurses, and all health professionals need to realize the problem, and patients need education in taking responsibility for their own health. Technical and professional progress has made past solutions inappropriate for the present and future. The "damn-the-torpedos — full speed ahead" philosophy is running us into the rocky shore.

### Reference

1. Bluestein PA. The nuts and bolts of Utilization Review. Qual Assurance Review 1988;3:11-13.

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Dr. Dickey is a retired orthopedic surgeon. His address is 145 Covington Place, Macon, GA 31210.

## SEPTEMBER

2-4 — *Callaway Gardens: Georgia Society of Internal Medicine/Georgia Chapter American College of Physicians Meeting.* Category 1 credit. Contact James Moffett, 938 Peachtree St., Atlanta 30309. PH: 404/876-7535 or 800/282-0224.

9 — *Atlanta: Hepatic Surgery.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

15-17 — *Sea Island: Georgia Surgical Society.* Category 1 credit. Contact William C. McGarity, M.D., 1365 Clifton Rd., Atlanta 30322. PH: 404/321-0111.

19-20 — *Atlanta: Second Annual Menopause Conference.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

14-16 — *Atlanta: Advances in the Diagnosis and Treatment of Cardiovascular Diseases.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

14-16 — *Savannah: Neonatology — The Sick Newborn.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

22-24 — *Hilton Head Island, SC: Frontiers in Nutrition.* Category 1 credit. Contact Div. of Cont. Ed. MCG, Augusta 30912. PH: 404/721-3967.

23-24 — *Atlanta: The Clinical Management of Sickle Cell Disease.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

23-24 — *Atlanta: Introduction Into Percutaneous Transluminal Angioplasty VII.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

23-24 — *Atlanta: Pediatric Cardiology for the Primary Care Physician.* Category 1 credit and AAFP prescribed credits. Contact: Davis Howell, PhD, Outreach Services, Georgia Baptist Medical Center, 300 Boulevard, Box 200, Atlanta 30312. PH: 404/653-4741.

26-29 — *Atlanta: Advanced Demonstrations in Percutaneous Transluminal Angioplasty XX.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

26-30 — *Atlanta: Modern Methods of Diagnosing and Treating Diabetes Mellitus and Its Complications.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

27-28 — *Atlanta: Public Health Service Policy on Humane Care and Use of Laboratory Animals.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

28-29 — *Atlanta: Georgia Chapter of the American Academy of Pediatrics Fall Meeting.* Contact Executive Secretary William C. Mankin, 4059 Land O'Lakes Dr., Atlanta 30342.

28-30 — *Unicoi State Park: Looking Ahead: Caring for Georgia's Aging Population, Seventh Annual Conference of the Georgia Rural Health Association.* Category 1 credit. Contact Pauletta Graves, Office of CME, Morehouse School of Medicine, 720 Westview Dr., Atlanta 30310. PH: 404/752-1629.

29-30 — *Atlanta: Stress and the Heart — Risks and Recovery.* Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

30 — *Atlanta: Recent Advances in Clinical Oncology.* Category 1 credit. Contact David Gordon, M.D., 1365 Clifton Rd., Atlanta 30322. PH: 404/727-6761.

30-Oct 1 — *Augusta: Current Concepts in Organ and Tissue Donation and Transplantation.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

## OCTOBER

5 — *Atlanta: Joseph S. Skobba Symposium (Psychiatry).* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

6-9 — *Sea Island: Georgia Orthopaedic Society.* Category 1 credit. Contact David F. Apple, Jr., M.D., 1938 Peachtree Rd., Ste. 710, Atlanta 30309. PH: 404/352-2234.

7-9 — *Atlanta: Annual Meeting of the Georgia Gastroenterologic Society.* Category 1 credit. Contact Steven J. Morris, M.D., 20 Linden Ave., Ste. 500, Box 27, Atlanta 30365. PH: 404/881-1094.





## ROSALYN P. STERLING-SCOTT, M.D.

Assistant Professor of Surgery, UCLA School of Medicine and Drew University of Medicine and Science, Los Angeles

Associate Surgeon, Department of Cardiovascular & Thoracic Surgery, Centinela Hospital Medical Center, Los Angeles

Major, U.S. Army Reserve

**EDUCATION** Rensselaer Polytechnic Institute, Troy, NY, B.S. Chemistry; NYU School of Medicine, New York, M.D.

**RESIDENCY** Boston University School of Medicine (Cardiovascular); Saint Vincent's and St. Claire's Hospitals, New York City (General Surgery)

**FELLOWSHIP** First Mary A. Fraley Cardiovascular Surgical Research Fellow at the Texas Heart Institute, Houston

**OUTSTANDING ACHIEVEMENTS** Author of numerous articles, including "Indications for Early Bypass Grafting Following Intracoronary Streptokinase"; author of "The Female Surgeon—Dawn of a New Era," chapter in *A Century of Black Surgeons—The U.S.A. Experience*; Board of Directors, Association of Black Cardiologists; Secretary, Drew Society

“The caliber of physicians you meet in the Army Reserve exposes you to new ways of looking at a problem. It's easy for young surgeons to become entrenched in one method, but in the Army Reserve you'll have the chance to work with outstanding physicians in your own specialty, and often learn new ideas that will help you to improve your own approach to clinical or research problems,” says Dr. Sterling-Scott.

The Army Reserve can offer physicians a variety of challenging options such as teaching, research, unique training programs, and the opportunity to practice in prestigious Army medical centers.

“Joining the Army Reserve enabled me to take advantage of a number of conferences, including one at Walter Reed, where I worked with thoracic surgical colleagues, while conducting my own research project.”

We understand the time demands on a busy physician. So the Army Reserve offers training programs that will allow you to be flexible about the time you serve.

For more information about specific programs, call tollfree 1-800-USA-ARMY.

**ARMY RESERVE MEDICINE.  
BE ALL YOU CAN BE.**





# A NEW H<sub>2</sub> Antagonist

# AXID<sup>®</sup> 300mg

## nizatidine

Effective once-nightly  
duodenal ulcer therapy available in a  
**Unique Convenience Pak**  
for better patient compliance



### AXID<sup>®</sup> nizatidine capsules

**Brief Summary:** Consult the package insert for prescribing information.

**Indications and Usage:** Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

Axid is indicated for maintenance therapy for duodenal ulcer patients, at a reduced dosage of 150 mg b.i.d. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

**Contraindication:** Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H<sub>2</sub>-receptor antagonists.

**Precautions:** General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

**Laboratory Tests:** False-positive tests for urobilinogen with Multistix<sup>®</sup> may occur during therapy with nizatidine.

**Drug Interactions:** No interactions have been observed between Axid and theophylline, chloridiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** A two-year oral carcinogenicity study in rats with doses as high as 300 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement

compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Teratogenic Effects—Pregnancy Category C—**Oral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers:** Nizatidine is secreted and concentrated in the milk of lactating rats. Pups reared by treated lactating rats had depressed growth rates. Although no studies have been conducted in lactating women, nizatidine is assumed to be secreted in human milk, and caution should be exercised when nizatidine is administered to nursing mothers.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**Use in Elderly Patients:** Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to

determine whether these were caused by nizatidine.

**Hepatic:** Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

**Cardiovascular:** In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

**Endocrine:** Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

**Hematologic:** Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H<sub>2</sub>-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs.

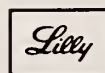
**Integumental:** Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients. Rash and exfoliative dermatitis were also reported.

**Other:** Hyperuricemia unassociated with gout or nephrolithiasis was reported.

**Overdosage:** There is little clinical experience with overdosage of Axid in humans. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LD<sub>50</sub> values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively. PV 2091 AMP [041288]

Axid<sup>®</sup> (nizatidine, Lilly)



**Eli Lilly and Company**  
Indianapolis, Indiana  
46285

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Axid<sup>®</sup> (nizatidine, Lilly)



## Tax Exemption Depends on Hospital Mission

The question of whether not-for-profit hospitals tax-exempt status can stand up may well depend on their individual missions.

At a recent American Hospital Association teleconference, Douglas M. Mancino, a tax planner with the Los Angeles law firm of McDermott, Will, and Emery, said that the tax-exempt survivors will be the hospitals whose purpose is to meet their communities' needs and whose services relate to that purpose.

Hospitals who are viewed more as business enterprises than charitable institutions may fail to retain a tax-exempt status, conference panelists said, and they agreed that the key is whether the hospital is viewed as a charitable institution or a business enterprise. For those perceived as business enterprises, a tax-exempt status may soon become a relic of the good old days.

## No Smoking or No Medicare

The Health Care Financing Administration is seriously considering making hospital smoking restrictions a condition for Medicare participation. In fact, HCFA's administrator William L. Roper has said hospitals should "take steps now that would preempt HCFA" from using "regulatory clout" to create a smoke free health care environment.

In addition, Surgeon General C. Everett Koop, M.D., has sent letters to hospital administrators encouraging them to ban smoking in the hospital "as quickly as possible."

Currently 90% of the nation's hospitals have smoking restrictions, but only 8% have banned it entirely.

## Small Hospitals Still Facing Problems

Nearly 600 of the nation's 2,700 rural hospitals are at risk of closing, according to recent testimony before the Senate Special Committee on Aging. Since 1980, approximately 161 rural communities have closed.

The primary cause, said speakers to the committee, is inequitable Medicare payments to rural hospitals, which receive up to 40% less than urban institutions for performing the same procedures.

Other factors contributing to rural hospitals' plight are a general recession in agricultural regions of the country, declining rural populations, and the large number of persons from rural areas who eschew local hospital care for treatment at larger urban institutions.

## Government Plans Medicare Education Program

Recognizing that the over-65 population generally does not understand Medicare's benefits, the Health Care Financing Administration is planning a public education program on all

aspects of Medicare, including new catastrophic care legislation.

HCFA's program will include public service announcements by HHS Secretary Otis R. Bowen, M.D., and a brochure that will be mailed to the more than 32 million Medicare beneficiaries. In addition, HCFA will set up a toll-free information hotline for the elderly and their families.

## Medicaid Digs Deeper Into Hospitals' Pockets

Georgia's Medicaid payments last year fell short of costs by about 14%, a percentage the state hospital association translates into a \$30 million loss to Georgia's hospitals. Yet the state has proposed a 2.8% cut in the Medicaid budget, which, at press time, was scheduled to go into effect in early July.

The proposed cut would mean a \$45 million loss for hospitals during the first year, and broken down, the Medicaid budget would look like this:

State pays	\$79 million
Federal government pays	\$154 million
Hospitals pay	\$45 million

"Few people realize that hospitals pay almost half what the state pays for Medicare," says Cal Calhoun, director of financial services for Georgia Hospital Association. In a hearing before the Department of Medical Assistance, Calhoun testified that expansions of the Medicaid program have caused the state to exceed its budget projections for certain providers, thereby leading the state to propose the cuts "under the guise of efficiency."

# Doctor, Before You Buy That Computer . . .

Robert R. Moore, Jr.

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## **An expert on medical office systems shares tips — and warnings — on how to select a computer for your practice.**

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**P**UTTING A COMPUTER in your practice can pay big dividends. It allows you to cost-effectively store and quickly retrieve vast amounts of patient information — both clinical and financial. It can automate your billing and accounting procedures, simplify record keeping and correspondence. A computer can boost staff productivity and make your practice more profitable. No wonder so many physicians are talking about computers today.

The only downside lies in selecting which system is right for you. There are literally hundreds of hardware and software products out there — as you probably know from the legion of salesmen and computer vendors trying to contact you. To make the best decision, you need the best available information. Selection and buying a computer for your office can be risky business. Mistakes can be costly, and they can devastate your practice. When the Medical Association of Georgia's Computers in Medicine Committee asked me for advice on how a physician should go about se-

lecting a medical office system, I offered two practical suggestions:

### **Know What You Need**

The first step in selecting a system is to take a long, hard *realistic* look at what is going on in your practice. The object here is to gather as much information as possible about the business of your office operations. It will be impossible to select among many different systems if you are not clear about what is being done in your office, and why.

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Mr. Moore is co-founder of Gates, Moore & Company, a prominent medical practice management consulting firm in Atlanta. He prepared this article at the request of MAG's Computers in Medicine Committee. Send reprint requests to him at 3399 Peachtree Rd., N.E., Suite 320, Atlanta, GA 30326.

For starters, look at the big picture. First, why do you need a computer? Develop a list of reasons and justifications. Determine if the manual methods and systems employed in your office can accommodate your current and projected needs. Compare the cost of manual methods with the realistic cost of an electronic data processing system.

Next, categorize your needs and evaluate them in three areas: (a) financial; (b) clinical; and (c) marketing. Your specialty and the size of your practice will markedly affect these, but in all cases you should document some important practice statistics:

- (a) **Patient volume** — average number of patients processed in the office per half-day session. Use a 2-week period to establish your data base. Keep in mind the total number of active patient medical records in your filing system. (We define "active" as a patient who has received treatment within the





last 36 months.) Do you anticipate any changes in patient volume over the next three years?

- (b) **Number of statements processed and mailed** for services rendered in your office, and in the hospital. You should be able to detail your billing cycle from date of service. Be sure to consider your procedures for handling Medicare and private insurance. And what if the patient is covered by more than one plan? How long do you continue to send statements on delinquent accounts.
- (c) **Number of insurance claims processed and mailed** — again, look at a two-week period. How many claims were processed?

How many were Medicare? Medicaid? Blue Shield? Workers' Comp? Other private carriers? Do you process claims on any form other than the HCFA 1500?

- (d) **Number of practice-related financial transactions** that occur during an average work week. Here, a variety of factors are involved, such as the average number of mail-in payments received and number of statements mailed. It would be helpful to analyze a sample of 75 charge tickets for office services and learn the number of patient visits with three or less services rendered; number of "no charge" visits; number of patient visits requiring in-

surance filing; number of visits paid at the time of service.

The complete evaluation of your office financial procedure includes also such questions as, is your established fee schedule consistently applied? Do you participate in an HMO or PPO program?

Financial needs are not the only variables to consider. You should also determine whether you have a need for specific *clinical* data to be maintained in a computer system. Do you currently maintain a status report on hospitalized patients? What other clinical applications would you require in a computer system? Do you have a recall system in effect? Think of the types of patients you would include in your



recall system — diabetics, hypertensives, cancer patients, etc.

In analyzing your practice, be sure to keep this rule in mind: a computer by itself will not solve problems in your office, nor can it organize and manage a chaotic medical office. Before setting out to buy a system, you need to be sure of your practice's management procedures. Without proper office procedures, the best computer system in the world won't help you.

### **Know What You Are Looking At**

No two medical practices are exactly alike. And no one computer system will work for all medical practices.

There are dozens of companies involved in the data processing business with a bewildering variety of systems installed in an equally bewildering variety of medical

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**The complete evaluation of your office financial procedures includes such questions as, is your established fee schedule consistently applied? Do you participate in an HMO or PPO program?**

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practices, both general and subspecialty. It is safe to say there is a system available today for almost every size and kind of a practice. You should select what you need and want, *not* merely whatever a salesman is selling. Armed with the right information, you can make a prudent decision that satisfies your objective, not the salesman's.

After assessing your needs, you will be in a position to start selecting a computer company. Chances are that you have already been contacted by several salesmen. Other

physicians, maybe the hospital administrator, or even the telephone book will provide the names of hardware and software firms.

The challenge comes after you have prepared a list of possible providers. For each, you should gather *reliable* information on the following points:

#### *About the Company*

1. Has the company been in business more than three years?
2. Does the company have ten or more computer installations it is supporting?
3. Has a credit check been conducted on the computer company?
4. Have references been checked?
5. Has an on-site evaluation of the system in another practice of your specialty been conducted?

#### *Hardware*

1. Is the computer hardware a nationally recognized brand?
2. Is the hardware a true multi-user, multi-tasking system?
3. Is the computer vendor proposing a network of personal computers? Why?

#### *Software*

1. Is the computer company supplying a generic medical software package that will be tailored to your specific needs?
2. Will the software accommodate your *specific* needs as defined and documented?
3. If specific programming requirements are necessary, is there a charge?
4. Has the specific system backup media and method been defined to include estimated time factors?

Based on your findings you should then limit your options to two or three vendors, submit a detailed explanation of your computer needs, and ask for a bid on the proposed hardware/software system. Always get competitive bids from at least two vendors.

When you receive your bids, ask yourself five key questions:

1. Has the vendor representing the computer company documented the commitments made regarding the system?

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**Much of the difficulty in choosing a system that is right for your practice can be eliminated.**

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2. Have the exact terms of the hardware and software support agreement been defined with annual cost?
3. Has the amount of training that will be provided been defined and documented?
4. Has a specific timetable for computer conversion been defined and documented?
5. Have specific requirements for power and telephone been detailed?

If all these points are covered to your satisfaction, and the proposed system meets your practice's needs, you're in a position to sign a sales agreement. Before doing so, however, you should implement these safeguards:

- a) ensure that all commitments have been documented and become a part of the sales agreement
- b) have your practice attorney review the sales agreement

**B**uying a computer for your practice is not a simple task. But much of the difficulty in choosing a system that is right for your practice can be eliminated. By assessing your needs, confirming the capabilities of vendors and their products, analyzing their capacity to meet your needs, and finally by double-checking the proposed sales agreement, you can help yourself make an enlightened decision that will benefit you, your staff, and your practice. ■



# Purchasing an Office Management Computer System — The Questions to Ask

Larry Miller

**A** MANAGEMENT COMPUTER SYSTEM streamlines a physician's office.

Doctors are often confused by computers and the services office management systems can provide. These systems are designed to make physician practices time and money efficient. An office management computer system is vital to a successful physician practice. But it is important to check into computer vendors and ask the right questions before purchasing a system.

## **Is the vendor a stable company?**

Does the vendor have staying power? Is the company financially strong? Can it withstand significant market changes such as a recession or slow-marketing cycle? What is the vendor's current market position and strength? Is the vendor strong enough to maintain or step-up the pace on software development? How long has the company been in business in your market?

Any vendor can survive in the market for a year or two. You should check with other customers and find

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**An office management computer system is vital to a successful physician practice. But it is important to check into computer vendors and ask the right questions before purchasing a system. Those questions are specified in this article.**

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Mr. Miller is Senior Vice President of Health Care Affairs for Blue Cross and Blue Shield of Georgia. He was previously the assistant vice president of The Network Group, a division of Blue Cross and Blue Shield of Georgia that markets computer systems to physicians, dentists, hospitals, dialysis clinics, home health agencies, and skilled nursing facilities in Georgia. Send reprint requests to him at Blue Cross and Blue Shield of GA, 3348 Peachtree Rd., P.O. Box 4445, Atlanta, GA 30302.

out if the vendor has been time-tested for stability. The true stability test comes in the third or fourth year.

## **Is the vendor willing to give you a service commitment?**

Is the vendor selling you a system without any service after the sale? When things go wrong, is the vendor going to be around to resolve the problem? Are old customers left out on a limb with no assurance of ever getting their problem solved? Is the vendor committed to superior service and improved performance?

The only way to check on a vendor's commitment is to talk to the people that deal with them every day. It is your right to ask for a long list of system users.

## **Does the vendor have good references?**

When you ask for references, are you getting excuses instead of a list? Is the vendor "just expanding into this area"? Is the vendor giving you reference for a different product than the one you are buying?

The best way to exclude questionable or weak companies from your choices is to ask for a list of references. A reference list should contain at least four users. With a more extensive list you can randomly select users and obtain a truer picture of a vendor's performance and a flavoring of how they do business.

Watch out for the following comments and look closely at the vendor when you hear them. A representative of a weak or questionable company usually makes statements like these.

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**If a vendor offers a price that is too good to be true, it probably is. You can often identify the first signs of internal problems from vendors when you notice them offering special prices on their systems.**

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We are just expanding into this area.

The reason our price is so low is that we are offering a holiday special.

We have just expanded into a new vertical market.

Yes, I have a reference for you and here it is.

We don't have that many sites installed yet, but sales are tremendous.

Let me give you the references that have our new software.

Yes, we do everything now.

We will give you a 24-hour response on everything.

It's in development, but it will be ready by the time you are installed.

With our software you will never have a problem.

We will give you any enhancements you want.

### **What are the system capabilities?**

In order to determine the system you want to purchase, you need to create a checklist based on office procedures you want to automate. Then list the procedures in priority order. Normally, the high volume repetitious activities will generate the most efficiencies in your office. The aging and collection reports on your accounts receivable and electronic claims will generate the greatest improvements in your cash flow and the greatest reduction in bad debts. The "bells and whistles" in a system can make a difference in your selection, but the key to an efficient computer system is whether or not it is functional for your immediate office needs.

### **Is the system easy to use?**

Your new computer will cause problems if your office staff does not understand or accept the system. You should include your office manager and representatives from your clerical staff in the selection of your system. Involving your office employees in the decision-making process could insure that your new system is acceptable and appropriate. These employees are best qualified to determine whether the software is user friendly. It is vital that your employees understand the system if the computer is to improve the management of your office. The system's training program is significant in your employee's smooth transition to a new office management computer system.

### **What kinds of system training does the vendor offer?**

Does the vendor offer flexible training sessions? Are they willing to do either on-site or off-site training? Does the vendor have service centers located within a reasonable driving distance of your location? Do their support staff work in your region? If you experience staff turnover, will the vendor retrain new staff on the system? Does the vendor have a toll-free WATS line for

user questions? What sort of follow-up mechanism does the vendor provide to insure that all calls and problems are resolved?

Your new system's training program is significant in the smooth transition to a new computer. You can't effectively train staff on a new system by phone or through a users' manual. It is important that anyone who uses the system learn about it through a vendor's professional hands-on training program.

### **Does the vendor offer system hardware and maintenance?**

It is best to purchase your hardware and software from the same vendor to eliminate capability and maintenance problems. By working with one vendor, you can solve problems faster and more efficiently. It also helps to have one vendor to hold accountable if there are problems. You should also have a on-site hardware maintenance contract to insure that your down time is held to a minimum.

### **Will your vendor help you finance your system?**

Does the vendor offer flexible financial alternatives to help you obtain a system? Can you lease or purchase your system? What level of flexibility is available under each method?

It is important that your vendor offers you a choice of financing methods for your new office management system. A lease is most advantageous when you do not want to worry about a large payout or if you are hesitant about owning obsolete hardware. However, a lease can be more costly over time, especially if your vendor's hardware maintains its value. Owning your system may have investment advantages over a longer period of time. Your individual needs should determine your financing option.

### **How will the vendor charge you for software enhancement?**

Does your vendor automatically include mandated changes as part of your software support agreement



or does new software have to be purchased separately? Will you have to purchase other system enhancements or are they automatically incorporated as part of the software-support fee? Are electronic claims part of a separate module or is the package purchased as part of the original system? Does the vendor ask for enhancement recommendations in person, by phone or in writing? Does the vendor request assistance in evaluating the potential of these suggestions? Are the enhancements adequately tested prior to release to other users? Are the vendors up-to-date on new services and industry movements?

Check your reference list and ask the vendor's current users how the vendor handles enhancements and changes.

#### **How does the vendor handle hardware expansion and upgrades?**

Does the vendor competitively price hardware additions or do they charge high prices to existing customers who are locked into the vendor's hardware? Does the vendor look for faster and more versatile hardware? Does the vendor insure that their users are aware of new capabilities and market changes?

#### **How much does the system cost?**

You usually get what you pay for with physician office management computer systems. The long-term poor performance of a low-cost hardware/software solution or ongoing support services can easily eliminate any value of that initial low-cost decision. Keep costs in mind, but let cost be secondary to selecting a vendor with good service, system capabilities and a long-term business relationship.

Be sure to verify what constitutes the true cost of your system. Many vendors segment their system prices into modules instead of a complete system. Vendors can also charge for separate modules for electronic claims. When you are comparing

system prices, make sure you are looking at equivalent systems. Make sure you have identified all additional cost such as software and hardware support fees. And make sure you understand the definitions of these additional costs. Some software support fees are designed to maintain current software and some are designed to enhance your system. Check into the conditions where separate charges apply. Your system cost will significantly increase over time if the enhancements aren't automatically part of the software support.

If a vendor offers a price that is too good to be true, it probably is. You can often identify the first signs of internal problems from vendors when you notice them offering special prices on their systems. Vendors often ask lower prices to solve a cash-flow problem for their company. The cash-flow problem generates a special sales offer, which generates a lower margin for operations. A lower operations margin may lead to service and support cuts which might create ill will among system users. If users are not happy with a vendor, they will not recommend the company and the company may have to lower prices again to survive. If you check with other physicians, you will find a number of horror stories that fit this pattern. So check out low prices and make sure your vendor is not in the middle of a cash flow problem.

#### **What about the system's electronic claims?**

What types of claims does the vendor currently transmit?

When checking electronic claims capabilities, only count lines of business that are currently being transmitted at user sites. It takes a long time to implement new electronic claims capabilities. It is difficult to enhance a system for additional electronic claims. Remember that the system that submits the greatest variety of claims is most valuable to your office.

In summary, some questions and answers to check on are listed below.

*stability* — Will the vendor be here next year?

*commitment* — Will the vendor's staff be there when you need them?

*references* — Will the vendor's system users recommend the company?

*system capabilities* — Which system gives your practice the greatest efficiencies?

*easy to use* — Is the software user friendly?

*training* — Will you receive individualized training?

*hardware purchase and maintenance* — Can you buy both from the vendor?

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### **To eliminate the necessity of multiple hardware or software packages for electronic claims, physicians should have a "clearinghouse connection" for their system.**

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*financing* — Do they have flexible financing alternatives?

*software enhancements* — What does the software support fee cover?

*hardware expansion and upgrades* — Will additional hardware be offered at a reasonable price and will it be up-to-date?

*electronic claims* — What types of claims are transmitted electronically?

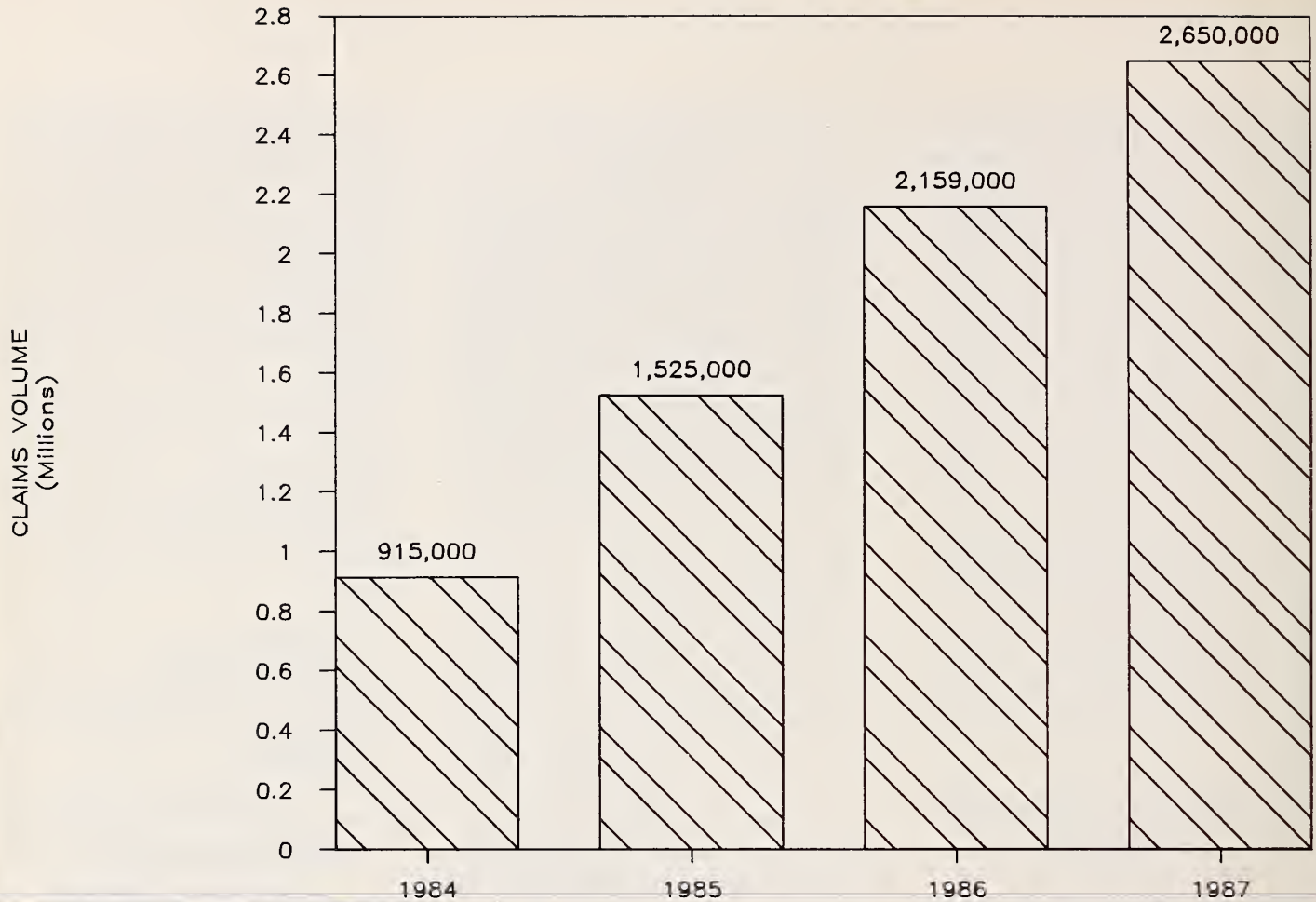
*cost* — What is the purchase value, not the cheapest solution?

#### **Claims Clearinghouse**

Once you make your choice for a physician office management

## THE NETWORK GROUP

### ELECTRONIC CLAIMS



computer system, or if you've already made your decision, you should make sure that your system is adaptable to electronic claims capabilities.

To eliminate the necessity of multiple hardware or software packages for electronic claims, physicians should have a "clearinghouse connection" for their system. At a minimum, a clearinghouse should provide services for Medicare Part B, Blue Shield, Medicaid and commercial carriers. Once these four capabilities are present, any office will improve cash flow and reduce rejected claims with their new systems.

The Network Group, a division of Blue Cross and Blue Shield of Georgia, offers a clearinghouse to physicians with any computer management system. The Clearinghouse Connection allows any vendor to connect with The Network Group's

system for electronic transmission and appropriate claims distribution to other insurance companies and programs. Vendors also have access to any additional clearinghouse activities that The Network Group develops in the future.

The physician and vendor will have the option to pick and choose the types of claims that they would like to transmit. There is a minimal monthly connection fee to the network, but if four lines of business or more are selected, no access fee will be charged. There are nominal transaction charges per claim submitted so you only pay for the claims you transmit.

With The Network Group's Clearinghouse Connection, you will not be charged for Blue Cross and Blue Shield of Georgia physician claims. The Network Group is working towards creating new connections to other carriers and states.

### Office Management Computer Systems — Move Towards the Future

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# Computer Retardation

W. Charles Pfister, M.D., F.A.C.P.

## Introduction

**H**AVING USED COMPUTERS in a variety of ways and settings since 1967, I have long been perplexed by what I call the "physician-computer paradox." Simply stated, this enigma is the baffling reluctance of physicians to use computers for their daily medical practice when they have so rapidly and readily adopted them for billing. (I am referring here to the use of computers by individual physicians for clinical and other chores, not technical computing by medical investigators or hospital departments.) Other professions long ago realized the power of these instruments to enhance and advance their work, yet physicians seem to have largely ignored this technology.

Only part of this lag can be attributed to the lack of suitable software and hardware. Over the past several years, powerful and reasonably-priced computers and software have been developed but

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largely not appropriated by physicians. This omission appears to be pervasive. I think that we have been as slow to adopt computers for specific medical purposes, such as clinical pharmacokinetics, as we have been for the more mundane functions of word processing, modeling, general computation, and medical record keeping.

I do not invoke the lack of "user-friendly software" or the expense of computers as the cause of our retardation. Instead, I attribute the major part of this lag or "paradox" to physician ignorance of the amazing capabilities of these instru-

ments. Accordingly, I think a short narration of how I use my computers would illustrate why I consider them to be such valuable adjuncts to my practice as a general hospital pathologist. My story might also encourage other physicians to avail themselves of these aids.

My first chore after arriving at the hospital is to flip on the lights; the second is to "boot up" my computer. I have a small "laptop" computer with a modem (a telephone wire communications device), a disc drive (external data storage medium), and a printer. I like this machine because of its portability; its small size and battery power enable me to use it anywhere. I use a wide variety of programs in the laboratory, some of which I authored. But the most powerful and useful programs that I utilize are the ubiquitous "industry standards" of PPterm<sup>1</sup> (a simple communications program that enables two computers to converse), dBase II<sup>2</sup> (a databased manager), Lotus 123<sup>3</sup> (a spreadsheet program), and Microsoft Word<sup>4</sup> (word processing). It is these programs (and why they are so valuable to me) that I will briefly describe.

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Dr. Pfister is a pathologist and is chairman of MAG's Computers in Medicine Committee. Send reprint requests to him at P.O. Box 747, Tifton, GA 31793.

### **PPterm and Colleague**

My day often begins with a search of the medical literature, by which I hope to obtain the necessary data to solve some current problem. Using PPterm and the computer's modem, I can access by telephone the large and numerous databases of BRS/Saunders Colleague.<sup>5</sup> By this method, I can search the complete MEDLINE file (the National Library of Medicine's bibliographic retrieval service), the complete text of many medical books, and other types of databases for information pertinent to the problem. If my search is fruitful, I can then read the abstracts (and often the complete text) of the papers I have unearthed "online." Should I desire a copy of the paper, I can order it from Colleague or from the Interlibrary Loan Office of the Medical Library of Emory University. I usually receive the article within 6 days.

This type of library service is not inexpensive; one pays for Colleague, the telephone connect time, and the copying service. But, since I do not have a large medical library at hand, the service has been invaluable to my pathology practice and to my continuing medical education.

### **dBase II**

When I discover a journal article that I believe may be useful in the future, I add it to my article reference file. I created this computer file of abstracts and references using dBase II. My file is very similar in format to MEDLINE in that each article record includes the authors, title, source, abstract, and "key word" descriptors (index words). The record also holds helpful notes that indicate the article type (review, letter, editorial, etc.), whether or not the pictures and tables are useful, and if I have saved a reprint in my archive.

By this method, I have created a very powerful system that superannuates the (now) "neolithic" index card file I formerly used. Using dBase, I can easily cross search my

article reference file in as many as seven dimensions. This foraging strategy rapidly extracts the references and data on any topic for which I have an interest. If the article has been placed in my file, I can find it fast; I can also retrieve any related article. Try that with index cards!

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### **I attribute the major part of this lag . . . to physician ignorance of the amazing capabilities of these instruments.**

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This system has had other serendipitous benefits. Because I compose my own abstract for every reference I place in the article file, I find that the data in the article are more firmly embedded in memory. My recall is enhanced. And, I find that the computer screen is far more comprehensible than the cryptic notes and shorthand cypher I used on the index cards. Errors are easily corrected, updates effortlessly added, and links to newer relevant articles readily attached.

dBase is an exceptionally powerful program for compiling and searching any type of related items. For example, I have used it to construct a super "ROLODEX<sup>TM</sup>" file in which I have saved any name, address, and telephone number that I may need in the future. Using dBase, the retrieval of the number for that arcane reference lab is now a simple matter.

### **Lotus 123**

Lotus 123, a spreadsheet program, is the most fantastic computer program I have ever seen. It is an intelligent electronic ledger whose "cells" can be filled with either a label, a number, or a mathematical formula. This electronic

tabular array readily models complex problems. The powerful arithmetic, trigonometric, logarithmic, statistical, and financial functions of Lotus 123 instantly process long columns and rows of data to calculate solutions.

The grandeur of Lotus 123 is its ability to solve equations. And, the program will quickly recalculate all formulas for any change in a variable. This is the source of Lotus 123's power. By manipulating the value of variables, the user can ask Lotus 123 to answer "what if" questions. The program's swift recalculation of all formulas lucidly displays both the direct and indirect effects of any change.

For example, pharmacokinetic models on Lotus 123 clearly illustrate the interdependence of dosage, absorption, distribution volume, catabolism, half-life, and excretion. The affect of any change in these parameters on blood drug concentrations is easily appreciated. Or, in a different model, a physician could follow the dynamics of his tax liability as his income declines because of Medicare retrenchment, malpractice inflation, and carrier processing delays.

I have used this potent program for hundreds of tasks: modeling drug kinetics, calculating antibiotic MICs, documenting the monthly laboratory workload, determining the productivity of each lab section and shift, forecasting future personnel needs, optimizing my charge structure for maximum reimbursement, etc. My laboratory has used Lotus 123 in many studies to determine the efficacy, cost, and value of one test method versus another. Lotus 123 has aided us in the determination of which tests to do "in house" and which to refer to reference laboratories. The program has been a great help; several projects would not have been feasible without it.

### **Microsoft Word**

Last, but definitely not least, is Microsoft Word. This versatile word processing program is suitable for



any writing chore: from formatting a small memo to writing a large medical textbook. Its power is composition. The program creates a plastic document in which text is effortlessly manipulated. No erasing or overtyping! The many functions of this program allow one to move or copy large blocks of text to any position in the electronic document. Document-wide search and replace operations can find and correct spelling errors. Insertions or deletions of a single word or a whole chapter are assimilated into the document instantly. One can test the utility of different words or phrases and try various type fonts for headings and emphasis. Tables and text can be formatted into one or more columns, each left, center, or right justified. Footnotes are automatically correlated, numbered, and formatted; the program will place them at the end of the doc-

ument or at the end of the page. Your choice. *Amazing!* Instead of just writing, Microsoft Word enables one to *compose!* The difference is important.

I no longer dictate my correspondence because it read just like dictation — poorly! Certain words were overused, others abused. The prose was convoluted and redundant, the syntax and grammar often erroneous. Today, because changes are so easily made in the electronic document, Microsoft Word permits the consideration of alternatives to every word and sentence. (It will even check my spelling!) Consequently, I believe my prose is more polished and accurate. Rather than detract from me, the documents I compose (instead of dictate) support my assertion that I am an educated gentlemen as well as a physician.

The computer programs I have

described are, by no means, the only ones available for these types of chores. Many other powerful programs are widely marketed. The availability of good software and cheap computers has become global; they can even be purchased through the mail. The diversity of available software to perform all sorts of tasks rapidly, accurately, cheaply, and easily is stupefying. Shouldn't physicians investigate the future to determine its usefulness for us?

### Notes

1. PPTerm is public domain software for the Hewlett-Packard Portable Plus computer written by Mark Horvath.
2. dBase II is a product of the Ashton-Tate Company.
3. Lotus 123 is a product of the Lotus Development Corporation.
4. Microsoft Word is a product of the Microsoft Corporation.
5. BRS/Saunders Colleague is a service of CBS. It has many data-bases on diverse topics, ranging from chemical abstracts to IRS publications.



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# GaIN: A Network of Physicians and Hospitals in Georgia

Opal Bartlett, Jocelyn A. Rankin, Susan T. Statom

## Case 1

*A patient with a family history of breast cancer which includes her mother, a sister, and an aunt, asks Dr. Worley about an article she had just read in a popular magazine about modifying one's diet to help prevent breast cancer. She asks Dr. Worley if there is any scientific evidence of this. Dr. Worley is aware of the many articles indicating that fatty diets and particularly the Western diet are strongly correlated to the development of breast cancer. She has heard of the use of diet to prevent breast cancer but is not sure of the scientific evidence. Dr. Worley tells the patient that she will try to collect some clinical articles about this for her patient to read and she makes an appointment for her to return in two weeks. After doing a GaIN Medline search on diet and breast cancer, Dr. Worley requests several articles from her hospital librarian. She has read the articles and is ready to discuss them with her patient upon her return.*

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**GaIN is Georgia's non-profit, university-based computer network that was designed expressly to meet the information needs of practitioners and hospitals within our state.**

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Ms. Bartlett is Director, Simon Schwob Medical Library, The Medical Center, Columbus, Georgia; Ms. Rankin is Director, Medical Library, Mercer University School of Medicine, Macon, Georgia; and Ms. Statom is Medical Librarian, Southwest Georgia Health Sciences Library Consortium based at Colquitt Regional Medical Center, Moultrie, Georgia.

Send reprint requests to Ms. Rankin, Mercer University School of Medicine, Medical Library, 1400 Coleman Ave., Macon, GA 31207.

## Case 2

*Dr. Levine, a hospital-based pediatrician, has been asked to present a conference on current issues related to learning disabilities. Using Bookends software on his personal computer, Dr. Levine maintains an electronic database of 3,000 articles. He locates several good review articles on learning disabilities in this database. However, he feels he needs some more up-to-date data. Dr. Levine accesses GaIN from the same computer on which he stores his personal reprint file. He searches GaIN Medline and finds a very recent citation which should provide him with pertinent information. Dr. Levine sends a message to his librarian who is also on GaIN and asks that this article be obtained for him by his deadline. Four hours later, after making rounds at the hospital, Dr. Levine picks up his article from the hospital librarian.*





# GaIN

**T**HESE SCENARIOS are not just visions of tomorrow; they are the reality of today. These physicians are but two of the more than 400 health professionals in Georgia who belong to the Georgia Interactive Network for Medical Information (GaIN) network. A few years ago, they would have had to stop by a medical library to search the printed journal indexes and the card catalog for information on each case. Now a computer provides them with 24-hour access to GaIN medical library information services.

Computers are an integral part of many medical practices. In Georgia, microcomputers are used in physicians' offices in a variety of ways. Most are used for record-keeping; many are also used for information retrieval and connection to remote databases such as GaIN, MEDLARS at the National Library of Medicine, BRS and AMA/Net.

With this range of computer applications already in place, computers may well serve as the means to integrate the practitioner's educational activities with practice

management. Such a linkage will meet a long-time goal of medical educators.<sup>1,2</sup> Manning and DeBakey concluded in a recent study of continuing medical education in the United States that, "We are optimistic that the computer will help physicians implement concepts of lifelong learning. Current technology makes this possible now. . . . The future can be extraordinarily bright for practicing physicians if they use computer technology creatively to link education to practice."<sup>3</sup>



GalN is Georgia's non-profit, university-based computer network that was designed expressly to meet the information needs of practitioners and hospitals within our state. Membership is open to all health care professionals in Georgia and adjoining states.

### Background

With start-up funds from the National Library of Medicine (NLM),\* GalN was established in 1984 and began providing online services to the network in January, 1985. The network functions through a multi-level system that connects practice sites, hospitals and clinics, and the GalN center at Mercer University School of Medicine (MUSM) Library in Macon, Georgia. The first GalN hospital members, the foundation upon which the institutional part of the network was built, came from among the membership of the consortium of Health Science Libraries of Central Georgia (HSLCG).<sup>4</sup> Now GalN serves 22 health care institutions located throughout the state as well as its more than 400 individual and practitioner members. (Figure 2)

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## GalN members do their own literature searches on a subset of the National Library of Medicine's Medline database.

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GalN was developed to respond to practitioners' needs. The information overload in the biomedical sciences is demanding that we devise more efficient and effective ways to locate relevant information. We must connect this information

to the patient care site. Finally, we need to equalize access to resources for both rural and metropolitan area physicians.

GalN was funded by the NLM to design an efficient, cost-effective functioning model for a state information system. The intent was not to replicate national services, but rather to create a database and retrieval system to meet immediate local needs. When access to national systems is needed, the GalN bridge, or gateway software, links GalN members to other larger computer databases. The GalN network has been so successful that it is serving as a model for a number of other states which are now planning or are in the early implementation stages of their own health information networks.

### Online Services

What does GalN provide for the Georgia physician? The following online services are available 24 hours a day, seven days a week:

- **Medical Literature.** GalN members do their own literature searches on a subset of the National Library of Medicine's Medline database. The GalN Medline subset contains up-to-date references and full abstracts for more than 400 different medical journals, and all of these journals are available within the GalN network. The subset consists of citations from the past 4 years. The database is updated monthly with computer tapes obtained from the NLM.

The GalN Medline subset is searched through a menu-driven user-friendly software package that recognizes key words and subjects. Beginning searchers need no special training to obtain one or two good references on clinical topics. More sophisticated researchers benefit from the *User Manual* and the "Maximizing GalN Medline" course offered by the GalN staff. After searching GalN Medline, GalN members can send an automatic message to the GalN center or the nearest GalN hospital library re-

questing a photocopy of one or more articles of interest.

During the last calendar year, the GalN Medline database was searched 4,053 times. While many GalN Medline searches are performed within the Mercer School of Medicine by students and faculty, more than half of these searches were run by remotely located health professionals using telephone access to the GalN system.

- **Books and Audiovisuals.** Print and non-print materials at the Mercer Medical Library and in the GalN hospital libraries are available through the GalN system. The online catalog function provides a computerized "card catalog" which contains records for books, journals, and other materials housed in the GalN libraries. The online catalog provides the entire network with the opportunity to share resources available within the state and to borrow and lend materials among the institutional and personal members.

To maintain the GalN online catalog, the MUSM Library provides a centralized cataloging service for GalN libraries. Participating libraries receive printed catalog cards and labels for their own use as a by-product of having their book and audiovisual holdings entered into the GalN database.

- **Electronic Mail.** Network members can "talk" to each other and to other member institutions through GalN electronic mail (E-mail). Members type in messages, which can be of any length, while online or upload them from personal computers. When the recipient connects into GalN, there is an announcement on the screen that a new message is waiting for him/her to read. Messages may be sent to one person or to many simply by typing the name or names of all recipients or mail groups.

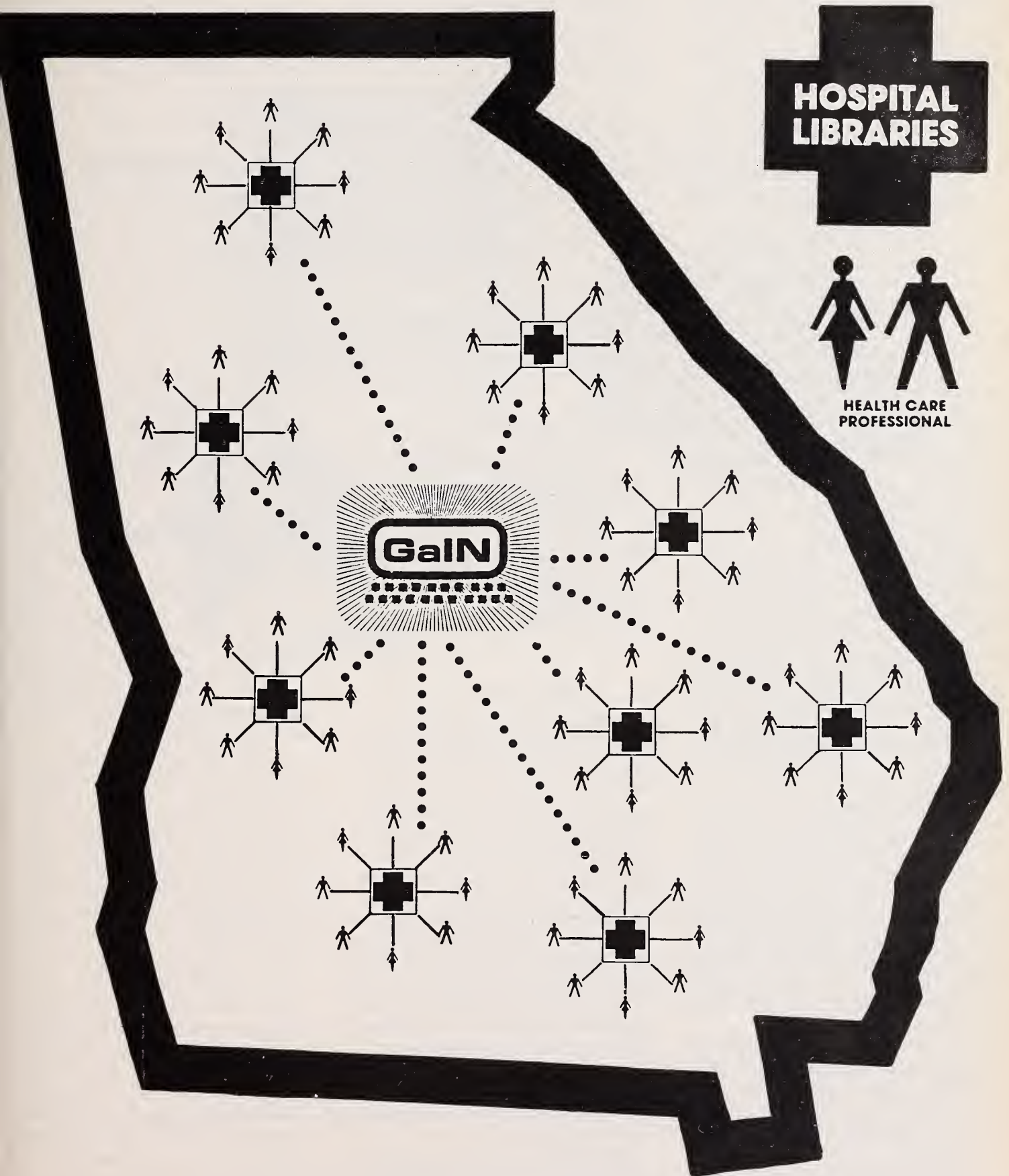
GalN's electronic mail service, unlike most commercial systems, allows for unlimited read and send privileges and for storage of messages. Messages can be retained in

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\*National Library of Medicine Grant No. G-08-LM04109 (1983-86). Operating costs are supported by institutional and individual fees.



# GEORGIA INTERACTIVE NETWORK FOR MEDICAL INFORMATION



an online filing system set up by participants and may be stored on the GalN computer as long as needed. Messages can be printed by either the sender or recipient.

One of the goals of the GalN grant project was to offer a mechanism for communication among network members and colleagues in the health care field. The electronic mail system has proved convenient and popular among network members. The E-mail system accounts for about 75% of GalN connect time.

● **Consultants Registry.** This database provides GalN members with names and information about health care specialists in Georgia who are willing and qualified to consult on medical problems. A GalN Consultants Registry Committee reviews the credentials of applicants for inclusion in the registry. GalN members can search the registry by keyword including name, specialty, location, and so forth.

● **Continuing Education Information.** GalN users can check this bulletin board for listings of continuing education opportunities in their field or areas of interest. The emphasis here is on programs available within Georgia and the Southeast. This file is also searched by keyword so that announcements are retrieved by topic, location, presenter, sponsoring organization and so forth.

● **GalN Gateway.** The gateway has a dual purpose. It is used by GalN members who are familiar with one or more national databases and who want to do their own searches. The gateway connects these members into Tymnet or Telenet and from there they utilize their own passwords to enter other systems such as the NLM's Medline, BRS Colleague, etc.

Second, the gateway provides the means to obtain and immediately deliver national database searches to the GalN membership. All gateway transactions may be stored on the GalN computer, edited as needed, and retrieved at a later date. GalN librarians use the gateway to perform and store full database

searches for GalN members. The requestors need only dial in to GalN to obtain completed searches. This feature thus provides for rapid delivery of searches to those physicians not wanting to perform their own literature searches.

● **Document Delivery.** The GalN center at the Mercer School of Medicine Library as well as participating GalN institutions will provide photocopies of articles needed by physicians. Requests for photocopies can be sent at the point of the search on GalN Medline or through the electronic mail to the local GalN librarian. Some GalN libraries charge a small fee for these photocopies.

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## **A GalN newsletter is published quarterly and includes information on new services, members, and tips for computer network users.**

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### **Hardware and Software**

Members dial into the GalN database from microcomputers or terminals in their homes or offices. (Figure 3) These microcomputers must have modems to establish the connection between the computer and the telephone lines. GalN is capable of communicating with a very broad range of computers that operate in an asynchronous environment. The most common GalN microcomputers are those with DOS or CP/M operating systems. The GalN staff can provide new users with information about microcomputers, modems, and communications software. Communications software is available commercially and also from public domain software (shareware).

The GalN host computer is a Digital Equipment Company PDP 11/44 minicomputer housed at the Mercer University School of Medicine

Library. The software packages supporting the network functions include Washington University School of Medicine's Bibliographic Access and Control System (BACS) and the Veterans' Administration Kernel, FileManager and Mailman.

### **Members Services**

GalN staff is available by phone during workday and some weekend hours to help members with hardware and software problems. In addition, GalN staff visits most areas of the state at least once annually. "House calls" are also made to members to help with system configurations when GalN staff is in the area. This readily available support differentiates the GalN network from national systems.

Each new member receives a *Users Manual* which provides instructions in use of the system. Members who have had some computer experience generally find the manual sufficient. Additionally, classes are offered on a monthly basis at the MUSM Library on GalN electronic mail, GalN Medline, and Maximizing GalN Medline. Each of these classes may also be taught as part of the annual site visit to GalN member institutions. CME credit is provided to participants.

A GalN newsletter is published quarterly and includes information on new services, members, and tips for computer network users. An Advisory Board composed of representatives of the membership helps with network planning. The librarians in the GalN institutions also meet regularly.

### **Conclusion**

GalN is providing a viable networking and information service for health professionals in Georgia. The network membership is growing daily and services are also expanding. Future plans call for the implementation of teleconferencing and computer-based accredited continuing medical education programs.

Before the network fully realizes its potential, however, at least two





barriers must be overcome. One barrier is computer illiteracy among health care professionals. While great strides have been made recently in the proliferation of computers in physicians' practices, much needs to be done to maximize these investments in hardware. Training responsibilities might be assumed by local and state associations as well as by the medical schools.

We must also improve the quality of data transmission via telephone lines. Telephone equipment in

Georgia varies in quality. Line noise is often apparent to computer network members. The future does promise improved modems and direct computer connects to be offered by the telephone companies.

GaIN is a first step for computer networking among health care professionals in Georgia. It is a beginning from which we can move forward to develop system interfaces and multi-level networking within the state. GaIN is the product of physicians and librarians from a number of different institutions

working together. It now provides a valuable support system for health care professionals. The ultimate beneficiary is the Georgia patient. ■

**For information about joining GaIN, call Ms. Bobbie Dever, Mercer University School of Medicine, at 912-744-4059. Annual membership for individuals is \$300 and includes a WATS number and unlimited access to the database. Membership fees for institutions are set according to size.**

# The National Library of Medicine, Computers, and the Garbage Can Method of Problem Solving

Nicholas E. Davies, M.D., F.A.C.P.

*"There's nothing really difficult if you only begin — some people contemplate a task until it looms so big, it seems impossible, but I just begin and it gets done somehow. There would be no coral islands if the first bug sat down and began to wonder how the job was to be done."*

JOHN SHAW BILLINGS, 1913

**A**PRIL 12, 1988, MARKED the 150th anniversary of the birth of John Shaw Billings, the great nineteenth century polymath who created *Index Medicus* and *Index Catalogue*, two of the most useful tools ever devised for medical bibliography. Billings was the Director of the Army Medical Library, later to become the National Library of Medicine (NLM), from 1865 to 1895. Besides being a Union Army surgeon, Billings designed the Johns Hopkins Hospital, hired William Osler from the University of Pennsylvania to become Chief of Medicine at Johns Hopkins, and di-

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**From the MEDLARS system has evolved MEDLINE, the world's largest medical literature database, now containing over 11 million references dating back to 1966.**

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rected the construction of the New York Public Library, which still stands on 42nd Street. Billings' meticulous indexes served the medical research, education, and practice communities well until the end of World War II. As William Welch wrote in 1914, "... building up and developing the surgeon general's library and in the publication of the *Index Catalogue* and the *Index*

*Medicus*" were the greatest contributions that America had made to medicine up to that time.<sup>1</sup>

"When Billings began to develop the *Index Catalogue* in the 1870s, he unwittingly converted the Library into a publishing house, half or more of whose employees would spend their working hours year after year preparing annual bibliographies."<sup>2</sup> The repetitive nature of the work suggested that much of it could be done by machine. In the 1950s, considerable time was spent by the NLM's director, Dr. F. B. Rogers, who sought ways to mechanize these chores. After several years of study and months of negotiations, using monies from the National Heart Institute, Rogers contracted with General Electric to develop the Medical Literature Analysis and Retrieval System (MEDLARS). It became operational in August, 1964. MEDLARS was to do more than just prepare the *Index Medicus* for printing. The systems designers built it hoping to have in it a searching ca-

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Dr. Davies practices internal medicine and is Chairman of the Department of Medicine, Piedmont Hospital, Atlanta. Send reprint requests to him at 35 Collier Rd., Atlanta, GA 30309.





*The low building in the foreground is the main library of the National Library of Medicine in Bethesda, Maryland. The Lister Hill Center is on the left.*

pability. And indeed it did. It was slow but it worked.

From the MEDLARS system has evolved MEDLINE, the world's largest medical literature database, now containing over 11 million references dating back to 1966.<sup>3</sup> The MEDLARS system now has 17,000 user access codes in all the major countries of the world. At one time in the 1970s, over half of all the world's entire literature searches were done on MEDLINE.

**T**o help meet the needs of the computer illiterates of the health care world, the Library developed a user-friendly microcomputer-based software package to get

into the MEDLARS databases. It is called Grateful Med, a name similar to that of a well known rock music group. Its advantages are that the user does not need to know the special language of the NLM system, it is relatively cheap, and the casual user gets full instructions on how to proceed with the search.

While some 17,000 users have joined Grateful Med and unknown numbers have subscribed to BRS Colleague and other medical literature databases, the vast majority of physicians have never done a computerized literature search and never plan to do one. Indeed, it is stated in a gloomy summary of the

information-seeking capabilities of physicians, done for the New York Academy of Medicine by Louis Harris Inc., that "over one quarter (26%) of office-based physicians do not have access to databases; 37% of those with access haven't used one in the past year."<sup>4</sup> The Harris study also observes that "office-based physicians are sorely out of touch with the advantages of online database technology . . . [the] use of this technology is glaringly limited. It would almost appear that this segment of the medical community is still in the horse and buggy days, so far as their information requirements are concerned."



One of the problems, of course, is that busy physicians need information quickly and cheaply, not characteristic of literature searches with a desk-top computer. So physicians use the information, knowledge, and wisdom that they have stored in that most marvelous of all computers, the human brain, during their years of training and practice, or they consult a textbook in their office, or they ask a colleague. Fortunately, many of the patients' problems seen in the average office practice are self-limiting. And those patients who have chronic diseases will be seen repeatedly, so that there is usually ample time to alter medications, change dosage schedules, or do new diagnostic studies.

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**To help meet the needs of the computer illiterates of the health care world, the Library developed a user-friendly microcomputer-based software package to get into the MEDLARS databases . . . called Grateful Med.**

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**T**he traditional method by which physicians are taught to solve problems has been called the "garbage can method." Perhaps "junk room method" would be a better term. Sadly, it still seems to be the method taught in most medical schools. It is done this way: Each discipline tries to cram into the heads of each pupil the essentials of that discipline, so that students end up with an enormous garbage can brain filled with loosely related or unrelated facts from which he or she may draw in the future. Rational

decision-making, using the latest information from the literature, is often not stressed in medical school. The garbage can method is then carried over into most residency programs. An internist, for example, is taught to do lumbar punctures, bone marrow aspirations, arterial line insertions, and other procedures that, unless he is practicing in a very small community, he will rarely do during the remainder of his career. The internist's avowed function is to do in-depth diagnostic workups of complex problems using the most modern techniques available, then formulate treatment plans using the best treatment modalities available and follow up these treatment plans carefully. Yet most internists are not taught modern methods for finding information, something they should use the rest of their lives if they remain in internal medicine. Old ways die hard. Even the American Board of Internal Medicine does not require that its candidates know modern methods for locating information; no questions about information gathering techniques are asked on their otherwise excellent examination.

Because medical schools and residency training programs have been slow to teach modern information gathering, there is not yet a critical mass of physicians who demand better databases than those currently available. And until better databases are available, many in academe will not want to use the student's valuable time teaching modern database searching techniques with inadequate databases. It is a "Catch 22" situation.

The problem may be changing, albeit slowly. The Association of American Medical College's GPEP report emphasized the need for life long learning.<sup>5</sup> It said, "Patient care, particularly clinical decision making, frequently requires the use of knowledge beyond the physician's background or memory. Skills in independent learning are indispensable components of the decision-making process. The biomedical

knowledge base can no longer be taught in its entirety; therefore, students or physicians must depend on their learning skills to identify and locate required information for their professional activities."

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**Old ways die hard. Even the American Board of Internal Medicine does not require that its candidates know modern methods for locating information.**

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**A** few medical schools are known to be moving into the Information Age. This is being stimulated by the NLM's Integrated Academic Information Management Systems (IAIMS) program which encourages academic health sciences centers to develop first-class health care information systems. IAIMS grants have been promoting health center information systems that make patient information, research information, administrative information, and health care databases all available at the same terminal.

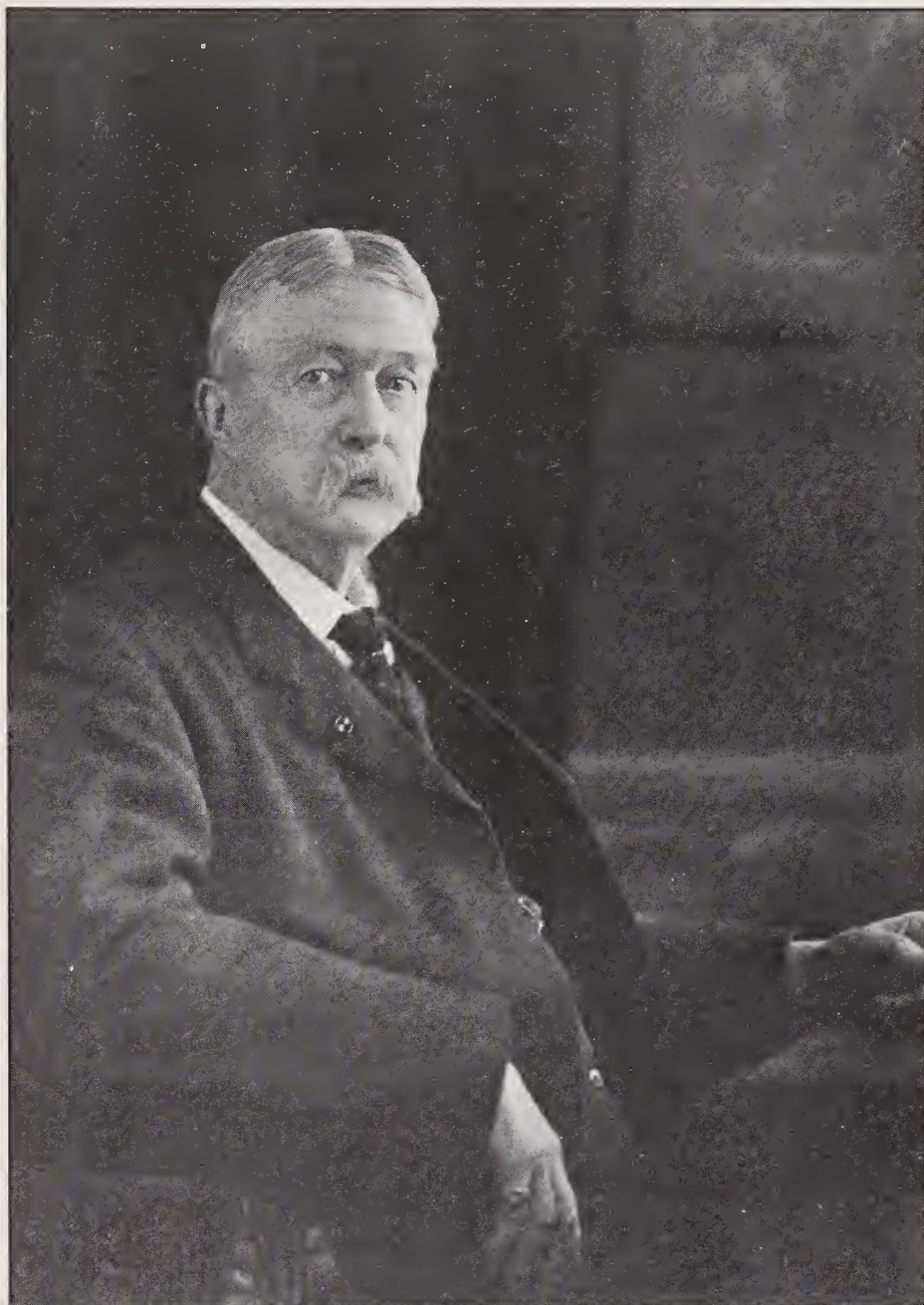
Carol A. Burns, Director, Health Sciences Center Library of the Emory University School of Medicine, recently discussed the problems of information transfer, in its broadest sense, before the Advisory Committee to the Director, National Institutes of Health. She said, "There is one weak link in this (the national health information) system. We have not yet devised an effective system for disseminating this information to practitioners throughout the country, particularly those without direct access to an academic health sciences center. While funding for biomedical research is of vital importance, so too is funding for the development of successful



information delivery systems." She noted that the good start made by the National Library of Medicine needs further development, "... specifically in terms of providing practitioners with the skills required for accessing this wealth of new knowledge in all areas of the biosciences."<sup>6</sup>

Ms. Burns further noted that a successful information delivery system depended in large part on the eagerness of the practitioner to seek and accept new knowledge. At present, most practitioners lack training in those lifelong learning skills that would prepare them to keep up with new biomedical knowledge or to retrieve information that once was learned but is now forgotten. She stated that "medical students continue to be taught using the traditional information-intensive methods as faculty attempt to have the content of their courses keep pace with the rapid advances in biomedical knowledge and technology. It's time for a change!"

**I**t is time, indeed. The change must come, first, from our medical schools and residency training programs. Our medical societies and library and information associations must also assume some of the responsibility. Medical schools must see that each graduate is at least computer literate, knowing where and how to find information needed for good patient management. Residency training programs, especially those stressing cognitive skills — internal medicine, pediatrics and family practice — must see that their residents are as adept at literature and database searching as they are at the now-required procedural skills of lumbar puncture, arterial line insertion, and thorocentesis. The examining boards of the cognitive specialties should test the skills involved in literature (and in the future, knowledge-base) searches. The learned societies serving these specialties, the American College of Physicians, the



*John Shaw Billings, born in 1838, created Index Medicus and Index Catalogue. Besides being a Union Army surgeon, Billings designed the Johns Hopkins Hospital, hired William Osler from the Univ. of Pa. to become Chief of Medicine at Johns Hopkins, and directed the construction of the New York Public Library that still stands on 42nd Street.*

American Academy of Pediatrics, and the American Academy of Family Practice, should develop programs to help their members keep their information-gathering skills current. Additionally, they should help develop knowledge-bases and artificial intelligence systems that would be instantly available day or night at any computer terminal for the use of physicians and others concerned with patient care.

Finally, our present national system, perhaps more aptly called our

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**Our present national system, perhaps more aptly called our national non-system, for medical information dissemination needs careful attention.**

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*John Shaw Billings in academic robes. This portrait hangs in the Reading Room of the National Library of Medicine.*

national non-system, for medical information dissemination needs careful attention. No longer is it

enough simply to publish an article in a scholarly journal and wait for the world to find it. A national med-

ical knowledge base would go a long way toward pointing out to practicing physicians the diagnostic and therapeutic modalities

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**A national medical knowledge base would go a long way toward pointing out to practicing physicians the diagnostic and therapeutic modalities available for the best patient care.**

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available for the best patient care. The National Library of Medicine, always a leader in information research, must give increasing support for this vital function. There is an urgent need for the development of a better method for disseminating information to the people who have the responsibility of caring for patients, the true end-users of our research efforts in medicine.

Perhaps by the year 2000 American medicine will have taken its proper place in the Information Age, an age that began in the United States, ironically, with the seminal work of John Shaw Billings.

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# How I Use a Computer in My Surgical Practice

William M. Headley, M.D.

**F**OR THE LAST SEVERAL YEARS, the members of the Computers in Medicine Committee of the Medical Association of Georgia have been gathering information on computer hardware and software so that we could make recommendations to the medical community in Georgia that would simplify introducing a computer into a medical practice. At first, this seemed like a relatively straightforward task. It has been anything but that.

For one thing, just in the last few years, the microcomputer field has undergone rapid change and substantial progress. We could recommend a computer that currently provides the most computing power, or that is the best bargain in terms of computing power per dollar, or a machine that has the most medical software available for it. But by the time our recommendation was published, it might well be out of date.

In addition, the variety of hardware and software is astounding. This is a boon to the user, but makes it difficult to recommend any one particular computer or software package for general use in all of-

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**A physician just starting practice can build into a computerized billing system codes for ability to pay, and methods can be devised to handle the problem of high patient turnover intrinsic to a general surgical practice.**

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fices. Needs vary among physicians, specialties, and practices.

**A**s an example, consider computerized billing, one of the first applications of the computer to be installed in many medical practices. If I were just starting a private surgical practice, without a doubt I would completely automate my financial record-keeping and billing. As it is, our office functions

quite well with a manual paper system. My head nurse/office manager and I opened the practice together 23 years ago. The office staff is experienced, with a minimum of turnover. We give considerable personal attention to our accounts: The practice sends about 150 bills each month, and a member of the staff looks at each bill to identify patients who are poor or temporarily unemployed or otherwise unable to pay the complete amount immediately. Even so, we have about a 93% collections ratio.

A physician just starting practice can build into a computerized billing system codes for ability to pay, and methods can be devised to handle the problem of high patient turnover intrinsic to a general surgical practice. But I was afraid that computerizing billing at this stage of my practice would only create trouble for the office staff and unnecessary hardship for the patients. In my case, a recommendation to computerize billing would be inappropriate.

For these and other reasons, we of the Computers in Medicine Committee found it difficult to make

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Dr. Headley practices surgery and has been Chairman of MAG's Computers in Medicine Committee. Send reprint requests to him at Medical Arts Building, P.O. Box 656, Milledgeville, GA 31601.

specific recommendations. Instead, several of us will from time to time write short articles explaining how we have found the computer useful in our own practices.

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### **I wanted to be able to compare the medium- and long-term efficacy and complications of different surgical procedures that I had used.**

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**A**n important and growing component of my surgical practice is surgery for morbidly obese patients. I keep extensive records on the clinical course of these patients. But it has only been in the last few years, since I computerized the voluminous bits of data about these patients, that I feel I have been able to use the information to optimize my surgery for morbid obesity. The data allow me to compare the efficacy of various surgical procedures, as well as their relative complication rates. In addition, I can determine the natural history of weight loss, how many patients need intraoperative or subsequent cholecystectomy, and whether and when weight is regained. It took several years and a number of false starts to reach this stage.

More than 20 years ago, I gradually became interested in the plight of the morbidly obese patient and began doing surgical procedures intended to aid them in permanent weight reduction. With the passage of time and continuing follow-up visits, large amounts of information accumulated on these patients. The number of these patients whom I had treated also increased greatly. And several new surgical options for treating morbid obesity became

available. It became increasingly difficult to organize all this information. Some was in the charts at the hospital, some was in my office records, and other data were in patient questionnaires that I had sent out.

More important, the information was not recorded in a way that allowed me to retrieve it and manipulate it to draw clinically useful conclusions. I wanted to be able to compare the medium- and long-term efficacy and complications of different surgical procedures that I had used. Did my experience support conclusions from other surgeons' series about which procedure was preferable? I had also modified the details of one procedure. Did the hard numbers support my impression that this modification was beneficial for weight loss?

I had more than enough data to be able to answer these and related questions. By 1983, I had done about 900 procedures for morbid obesity. Up to 50 items of information might be recorded for each patient. Yet I could not access this potentially valuable information in such a way that I could use it to improve patient treatment. Here was a database problem that was becoming increasingly complex.

**T**he only logical approach was to computerize the data. I purchased an IBM PC computer equipped with the DOS operating system, a printer, a modem, and the word-processing program, WordStar. After struggling with this system for several months, it seemed to me that I was getting no closer to arranging my data in a useful form.

So I approached a computer programmer. He asked what exactly I wanted in my data collection program. I didn't know exactly. It became obvious from conversations with him that programming can be very expensive and that there would be increasing expense with each change in the program.

At this point I found what has been for me the solution. It is a software program called Sym-

phony, from the Lotus Development Company. Symphony is unique in that it allows the user to write his own software program. You can record your data in any fashion you desire. You can then set your own criteria for retrieving the information, display it in tables or graphs and perform statistical analysis on it.

It is the *flexibility* of Symphony that makes it so useful for my purposes. Information only needs to be entered one time, and it is available for use in hundreds of ways. For instance, once a patient's weight loss history is entered, it can be retrieved and categorized by age, gender, initial weight, type of surgical procedure, or any other parameter that is also entered in the patient's computer file. Any outcome variable can be used to assess the efficacy of a number of treatment variables.

This capability is very useful for a physician who does surgery for

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morbid obesity. It is important to be able to generate updates to the data that include results from all patients. Surgery for morbid obesity is frequently refined, and periodically it is altered radically. Detailed, statistically valid comparisons are crucial for identifying as rapidly as possible proposed innovations that are truly beneficial to the patient and eliminating those that may be theoretically sound but that don't work out in practice.



Symphony makes this constant updating and evaluating possible. In our practice, more than 20 years of data on over 1300 morbidly obese patients have so far been entered and frequently evaluated. Does a change in the size of the surgically created stomach pouch or in the size of the opening into the pouch or in the size of the gastrojejunostomy affect the rate or duration of weight loss? What are typical post-surgical changes in patients' weight, blood pressure, cholesterol, triglycerides, or uric acid level?

All these data can be extracted, graphed, and compared. The data can be displayed as line, bar, or pie graphs. Graphs can be exported into another program called Lotus Free Lance for more sophisticated editing. Print can be changed or text added. Free-hand drawings in color can be used to clarify the graphs. And finished graphs can be mated with text to provide a complete manuscript.

I have given frequent presentations at medical meetings on the results of these operations. Having a computerized database in the Symphony program makes it possible to generate the most recent results in a minimum of time with a minimum of effort.

**H**aving the data stored in the computer has also made it possible to generate professional-looking slides for use in these presentations. There are two options for making these slides. Graphs can be produced by the computer and sent to a commercial laboratory. Using this procedure slides cost between \$25 and \$75 each. However, for a person who makes frequent presentations and needs new, updated slides each time, there is a simpler, cheaper way to generate high-quality

slides using your own computer. What is necessary is an enhanced graphics card in the computer and an enhanced graphic adapter monitor. Then high-quality slides can be

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**Should you decide to computerize your office completely, a number of very good companies offer packages that probably are cheaper in the long run than setting up your own system from components.**

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made by photographing the screen using the appropriate shutter speed and film.

Even for physicians who do not work in fields that undergo frequent innovations or who do not give regular meeting presentations, Symphony can be advantageous. A family physician, for example, might find it useful to have extensive clinical patient data recorded in a flexible computer program. A patient's longitudinal health history can be stored in an organized way that makes it clear whether a disease condition is progressing or a treatment is working.

Symphony also offers the capability of adding new information fields. If a physician decides to intervene with cigarette-smoking patients, information on patients' smoking history can be retroactively entered into the computer-

ized medical chart.

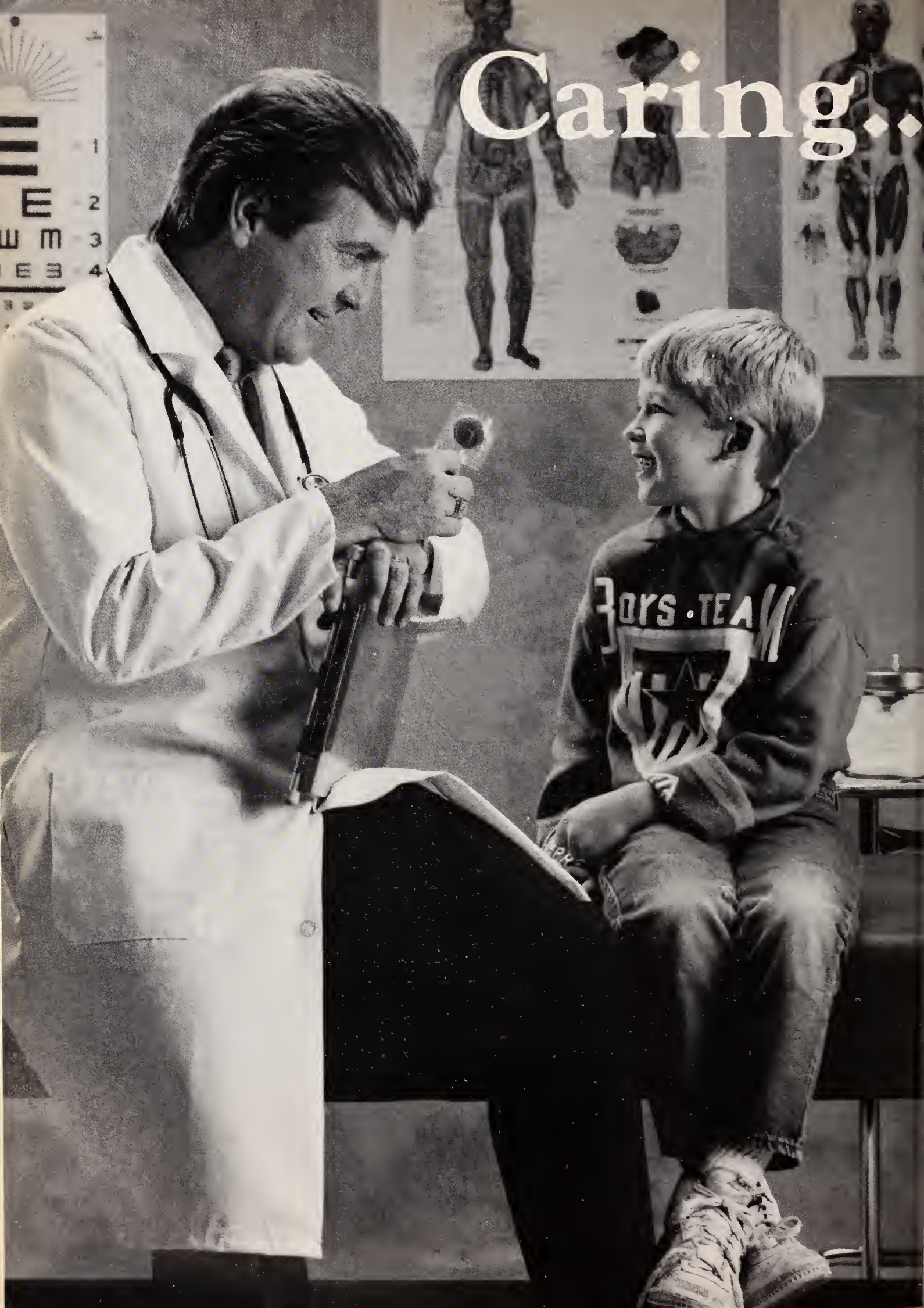
Symphony also has a communications component that provides access (via a modem and telephone) to various databases, such as MEDLINE at the National Library of Medicine. In the same way, I can connect to the Georgia Interactive Network for Medical Information (GalN), located at the Mercer University School of Medicine in Macon. Through GalN, I can perform a literature search or use the physician's bulletin board ("electronic mail") to communicate with other physicians.

**U**ses for the computer in the medical practice are numerous. But computers are really not user friendly and often are intimidating when one first begins to use them. Should you decide to computerize your office completely, a number of very good companies offer packages that probably are cheaper in the long run than setting up your own system from components. These companies provide computers, software (including medical programs that will meet your specific office needs), training for you and your office staff, and — most important — support when you need it. Of course, such a comprehensive arrangement is expensive, costing between \$20,000 and \$50,000.

On the other hand, should you have projects that you would like to try on your own, a number of very good computers, plus matching software, are available for between \$2000 and \$3000. These machines will get you started and give you a firm base to grow on should you decide that a computer isn't so intimidating after all and that one can help solve some of the problems in your medical practice. ■



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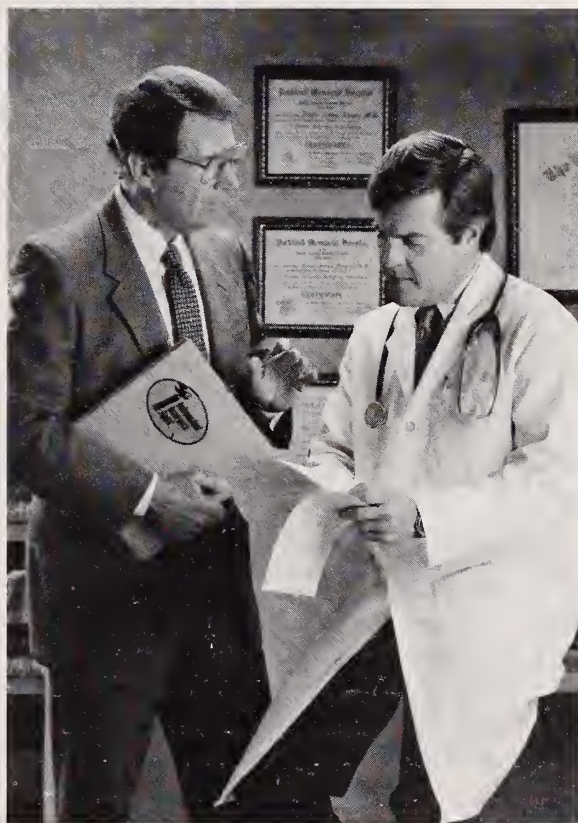
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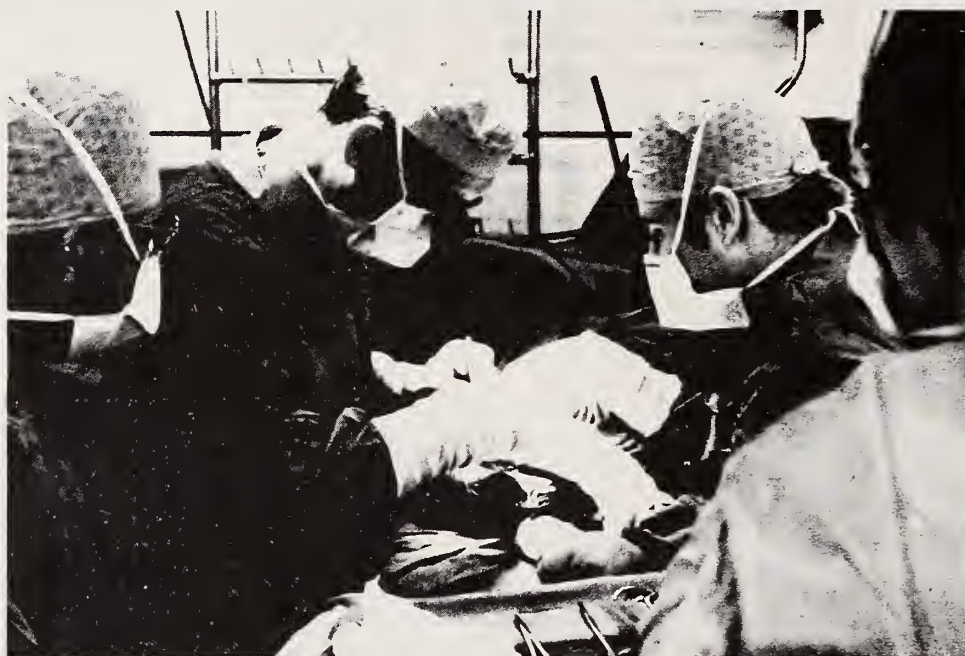


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# SIDS and Autopsies: Does the Medico-Legal System in Georgia Work for SIDS Deaths?

Barbara N. Samuels, M.D., M.P.H., Susana Rubio, M.P.H.

## Abstract

**S**udden infant death syndrome (SIDS) is the leading postneonatal cause of death in Georgia. By definition, SIDS is a diagnosis of exclusion requires a post-mortem examination to rule out other possible causes of death. Nevertheless, many infant deaths are labelled SIDS without an autopsy. State autopsy rates improved from almost 50% in 1980 to 65% in 1985, but most of the improvement occurred by 1982. Autopsy rates throughout the 1980s exceeded 90% in Cobb-Douglas, DeKalb, and Fulton health districts, while improving in the rest of the state from 35% in 1980 to almost 60% in 1985. The higher autopsy rates in the three metropolitan Atlanta health districts may be the result of a different death investigation system in those districts versus the rest of the state. Better facilities and a greater number of pathologists, including pediatric pathologists, probably contribute to the higher autopsy rate, as well. SIDS deaths in the three metropolitan health districts are almost always certified by medical examiners, while those in the rest of the state are usually certified by coroners or physicians other than medical examiners. More unautopsied SIDS deaths were certified by coroners or physicians other than medical examiners. All SIDS deaths in the three metropolitan Atlanta health districts certified by medical examiners were autopsied, but 20% of those certified by medical examiners in the rest of the state were not autopsied. The death investigation system as currently legislated in Georgia has increased the autopsy performance for SIDS deaths, but improvement is still needed.

autopsy to rule out other causes of death. Yet, SIDS victims are not always autopsied. Autopsies that are done are not always complete or adequate. Whether or not a SIDS autopsy is performed or adequate is subject to a variety of conditions, including the personal philosophy, commitment, awareness, and sophistication of the medico-legal community and the availability of funds, pathologists, and adequate autopsy facilities.<sup>5-7</sup> How these factors influ-

\* SIDS is the unexpected sudden death of an apparently healthy infant that remains unexplained even after an adequate autopsy. By definition, SIDS is a diagnosis of exclusion, requiring a post-mortem examination to rule out other plausible causes of death.<sup>1</sup>

**S**UDDEN INFANT DEATH SYNDROME (SIDS) is the leading postneonatal cause of death in Georgia. Between 1980 and 1985, the state mortality rate for SIDS ranged from 1.5 to 1.8 deaths per 1000 live births, consistent with the national SIDS rate of 1.5-2.0 deaths per 1000 live births.<sup>1,2</sup> In 1985, there were 154 deaths attributed to SIDS in Georgia, a rate of 1.6 deaths per 1000 live births.<sup>3,4</sup> SIDS is, by definition,\* a diagnosis of exclusion, requiring an

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ence the performance of autopsies on SIDS deaths in Georgia is not known, particularly in rural areas of the state, where the conditions noted above are more likely to deter the performance of autopsies.

A 1981 survey of medico-legal systems in nine states attributed high autopsy rates for SIDS victims to the presence of infant death or specific SIDS legislation and, more importantly, to a death investigation system that emphasized a central reporting mechanism with a coordinator such as a chief medical examiner.<sup>7</sup> In Georgia, the Post-Mortem Act<sup>8,9</sup> outlines procedures to be followed for specific types of deaths, but there are essentially two different death investigation systems in the state: a medical examiner system in Cobb, DeKalb, and Fulton counties, and a mixed coroner/medical examiner system in the other 156 counties. The coroner in each of these 156 counties is an elected official not required to have a medical background. The coroner is notified when persons die under conditions specified by the Post-Mortem Act, such as the death of an apparently healthy person or a death unattended by a physician, both of which can apply to SIDS victims. If death has occurred under either condition, the coroner must contact a state approved medical examiner (ME), who is licensed to practice medicine in Georgia, but need not be a pathologist. In the three counties with only medical examiners, the MEs must be pathologists. These MEs are also on the state list and can be used by any county coroner. In both systems, only the ME has the authority to decide whether an autopsy will be performed.<sup>† 8,9</sup> While the literature suggests that the medical examiner system may be more adept at obtaining autopsies than a coroner or mixed coroner/medical examiner system in at least one state,<sup>7</sup>

this has never been investigated in Georgia.

The Post-Mortem Act requires medical examiners to send all autopsy reports to the Forensic Science Laboratory of the Georgia Bureau of Investigation (GBI). Autopsy reports sent to the GBI are reviewed by a medical examiner or a pathologist. It is not known how many autopsy reports from SIDS deaths are actually sent to the GBI as required under Georgia law.

### Methods

Aggregate data for autopsies and geographic location (health district of death) were provided by the Vital Records and Health Statistics Unit of the Georgia Department of Human Resources from all infant death certificates in Georgia between 1980 and 1985 listing SIDS as the cause of death. Trends for SIDS deaths and autopsies were examined for the entire state and for Cobb-Douglas<sup>‡</sup>, DeKalb, and Fulton health districts (metro) versus the rest of the state. Certifier, autopsy, geographic location (health district of death), and death certificate numbers were abstracted directly from the 1983-1984 death certificates by one author (SR), and the relationships of certifier to autopsies and health district were investigated. Death certificate numbers were used to search the GBI records to determine the percentages of autopsy reports sent to the GBI, and health district information was used to determine if there were any relationship between the death investigation system or geographic location and reporting to the GBI.

### Results

Autopsy rates for SIDS victims appear to have stabilized since 1982 (Table 1). Autopsy rates for the metro health districts have been

consistently at or above 90% throughout the 1980s. Improvements in autopsy rates for the rest of the state occurred primarily between 1980 and 1982, exceeding 50% since 1982.

Coroners certified 163 of the 304 (54%) deaths attributed to SIDS that occurred in Georgia to state residents during 1983-1984; medical examiners certified 98 (32%); physicians other than medical examiners, 43 (14%). Medical examiners certified 94% of the 85 SIDS deaths that occurred in the metro health districts (Figure 1). Coroners certified 73% of the 219 SIDS deaths in the rest of the state; medical examiners, 8%; and other physicians, 19% (Figure 1).

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**SIDS deaths in the three metropolitan health districts are almost always certified by medical examiners, while those in the rest of the state are usually certified by coroners or physicians other than medical examiners.**

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If a medical examiner certified the SIDS death, there was a 96% chance that an autopsy was performed on that infant, compared to 59% if certified by a coroner and 42% for certification by a physician other than a medical examiner (Table 2). In the metro area, 100% of deaths certified by a medical examiner or another physician were autopsied, but only 33% (one of three), of coroner-certified SIDS deaths were autopsied. In the rest of the state, there was a 59% autopsy rate for coroner certified SIDS deaths; 39%, if certified by a physician other than a medical examiner; and 78%, if certified by a med-

† Byron Dawson, Ph.D., Assistant Director, Division of Forensic Science, the Georgia Bureau of Investigation contributed his knowledge of the death investigation system to both this and the following paragraph.

‡ Data were made available by health district. DeKalb and Fulton counties are synonymous with DeKalb and Fulton health districts. Cobb County is one of two counties in the Cobb-Douglas health district. Douglas County uses a coroner system.

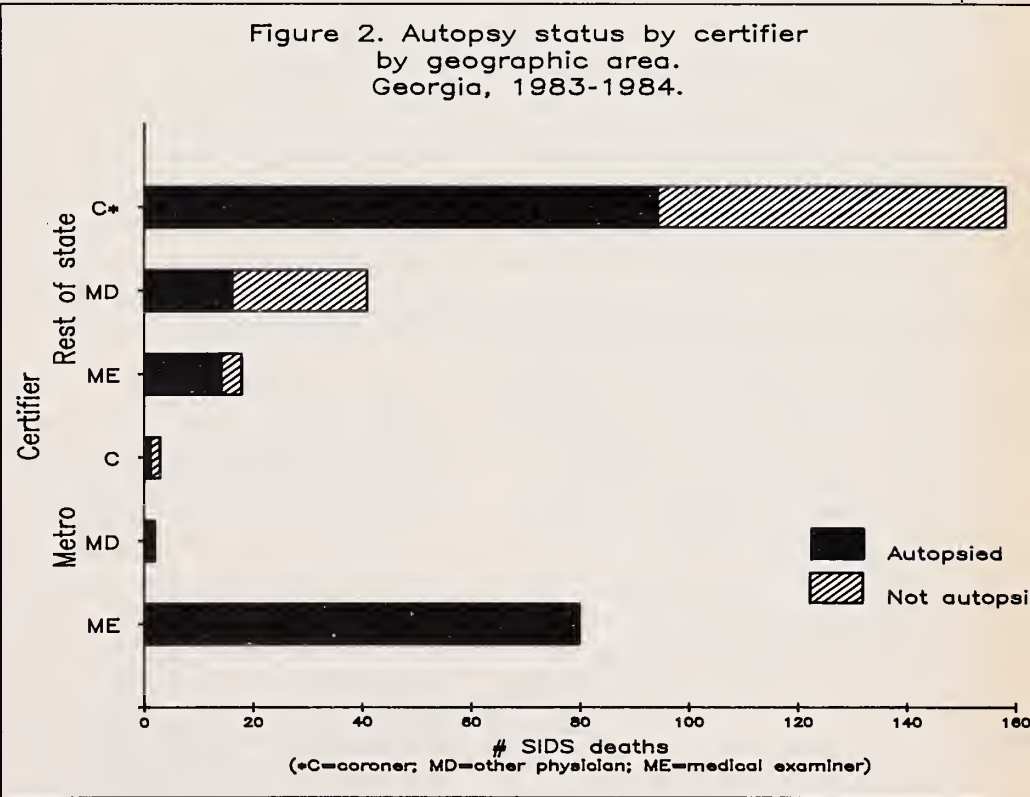
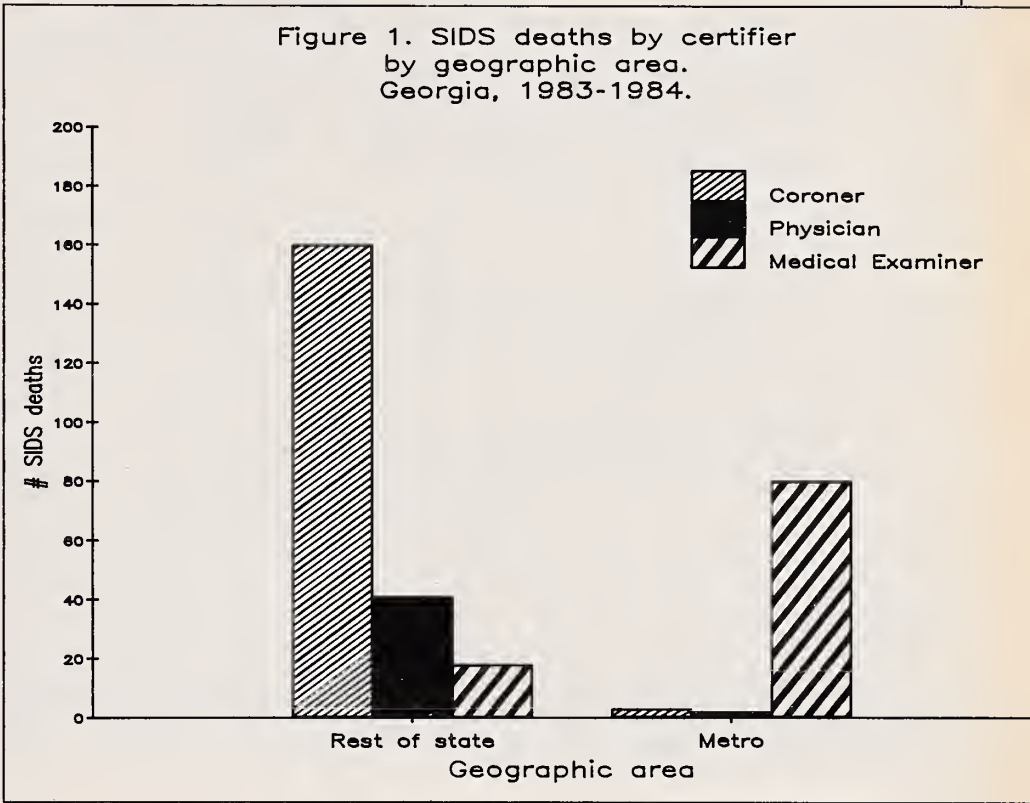


ical examiner (Figure 2). Two death certificates were missing autopsy information. Both were from outside the metro health districts and were certified by coroners. The three SIDS deaths that befell Georgia residents outside of the state were all autopsied. One was certified by a medical examiner; two, by other physicians.

Of the 305 death certificates for deaths attributed to SIDS that occurred in the state to Georgia residents during 1983-1984, a total of 208 (68%) were autopsied. Reports for 166 (80%) of the autopsies were sent to the GBI headquarters in Decatur as required by law. One death was determined not to be SIDS. Five reports in the GBI computer listing were not found in the GBI files. Three included only the police investigation report, and seven, only toxicology reports. At least 40% of the autopsy reports from four health districts located in different sections of the state were not sent to GBI. All used mixed coroner/medical examiner death investigation systems. Three are predominantly rural districts. All but one of the five autopsy reports not found in the file were from one health district in south Georgia. Incomplete reports (those containing only the police report or the toxicology report) were all from Cobb-Douglas and Fulton health districts. None of the three out-of-state reports was sent to the GBI.

Discussion

Autopsy rates for deaths attributed to SIDS in Georgia improved 40% from 1980 to 1982, but have shown no substantial improvement since that time. Most of the improvement occurred outside of the metro health districts. The improvement probably resulted from an increased awareness of the role of autopsies in SIDS diagnosis, since no major change in the law or in the death investigation system paralleled the improved autopsy rate. That non-autopsied SIDS cases were almost exclusively certified by coroners and physicians other than



medical examiners appears to support the premise that it is the death investigation system that determines autopsy rates. However, coroner certification of a non-autop-

sied SIDS case could represent refusal of a medical examiner to order an autopsy despite a coroner's request for one, since under Georgia law, only the medical ex-

**TABLE 1 — SIDS Deaths and Autopsy Percentages, Georgia, 1980-1985**

Year	#SIDS Deaths	% Autopsied		Total
		Cobb-Douglas, DeKalb, Fulton	Rest of State	
1980	134	91	35	49
1981	166	97	42	53
1982	137	90	58	65
1983	150	100	53	67
1984	158	97	61	70
1985	154	95	57	67

**TABLE 2 — Autopsy Status By Certifier, Georgia, 1983-1984**

Certifier	No. of SIDS Deaths*	
	Autopsied	Not Autopsied
Coroner	95	66
Physician	18	25
Medical Examiner	94	4

\* Autopsy status was missing on two death certificates; a third had its diagnosis changed by autopsy. This table does not include three Georgia deaths that occurred out of state and are included in vital records data presented in Table 1.

aminer can actually order an autopsy. In addition, rural families are known to turn more often to their family doctor upon discovery of a dead infant than urban or suburban families, and their physician may certify the death without activating the death investigation process.<sup>7</sup> Indeed, outside of the metro area, almost one-fifth of the SIDS deaths were certified by other physicians (versus two deaths in the metro area), and over half of these deaths were not autopsied, a much higher percentage than either coroner or medical examiner certification. A county-specific analysis might better determine whether it is the death investigation system per se or the urban or rural nature of an area that determines autopsy rates for SIDS victims in Georgia, since many rural health districts include an urban county.

Autopsy reporting to the GBI was generally good, although a few health districts were underreporting. Since county information was not collected, it is not clear whether particular counties in these districts did not routinely send their reports to the GBI or whether these

were random cases from different counties in an entire district. Again, a county-specific analysis might clarify the issue. There is no particular geographic predilection for good or bad reporting to the GBI. The districts with the poorest compliance have coroner/medical examiner systems, but a strict medical examiner system does not guarantee 100% reporting of complete autopsy results to the GBI.

### Conclusion

Based on this analysis, it appears that the medical examiner systems in Cobb-Douglas, DeKalb, and Fulton health districts are better at procuring autopsies for deaths attributed to SIDS than the coroner/medical examiner systems in the rest of the state. That the urban/suburban setting of those three health districts, with a greater availability of personnel and facilities to do pediatric autopsies, might be more important in procuring autopsies on presumed SIDS victims than the death investigation system per se cannot be ruled out. Moreover, a strict medical examiner system is probably unworkable in many areas

of the state. The more rural areas could not attract pathologists, particularly pediatric specialists, nor could they maintain costly forensic facilities that would be used sparingly, at best. A more practical approach would be to utilize the current system to its maximum potential. This would include ongoing SIDS education to update coroners, medical examiners, and other physicians about the syndrome and the central role autopsies play in its diagnosis. Periodic updates for pathologists, for example, on the techniques of pediatric autopsies, might improve both the number of autopsies performed on these infants and the content of the autopsies. Increased funding for autopsies would probably improve autopsy rates in many rural areas.

**In Georgia, the Post-Mortem Act outlines procedures to be followed for specific types of deaths, but there are essentially two different death investigation systems in the state. . . .**

One short term solution for improving autopsy rates of deaths attributed to SIDS is infant death legislation.<sup>5,7</sup> While such legislation does not guarantee much higher autopsy rates than Georgia's, two of the three states in the nine state survey with either SIDS legislation or infant death laws had autopsy rates at or near 100%.<sup>7</sup>

Another possibility is regionalization of forensic facilities and/or identification of pediatric pathology facilities as consultant centers similar to the tertiary maternal and infant care centers in the state. Regionalization of services has been implemented in many states with



varying degrees of success.<sup>7</sup> However, high autopsy rates in states such as North Carolina and Oklahoma occur in regionalized systems functioning under a Chief Medical Examiner.<sup>7</sup> Georgia has a central autopsy reporting mechanism already in place at the GBI Forensic Science Laboratory, but the Georgia agency reviews, rather than requests, autopsies. In other words, it acts at the end of the death investigation process rather than near the beginning. Regionalization has resulted in improvements in maternal and neonatal health in Georgia. Could a similar system improve the death investigation system for SIDS in the state?

### Acknowledgments

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## *Incidence of Oral Cancer in Atlanta*

Wong-Ho Chow, Ph.D., Jonathan M. Liff, Ph.D., Raymond S. Greenberg, M.D., Ph.D.

### Introduction

**D**URING 1987, an estimated 29,500 malignancies of the oral cavity and pharynx were diagnosed in the United States, and 9,400 people died from this disease.<sup>1</sup> Although oral and pharyngeal neoplasia accounts for only about 3% of all cancers, it is one of the most rapidly increasing neoplasms among black males, with an overall increase in incidence of 29% between 1975 and 1984. In contrast, the incidence of oral and pharyngeal malignancies among black females and whites remained relatively stable during the same time period.<sup>2</sup>

The demographic variation in incidence trends may reflect a temporal change in the prevalence of risk factors for oral cancer within subgroups of the population. Examination of the patterns of disease occurrence also may help to identify populations that would benefit from more intensified prevention and screening programs. The purpose of this report is to

### Abstract

**A**LL RESIDENTS of metropolitan Atlanta with a new diagnosis of histologically confirmed squamous cell carcinoma of the tongue (n = 320), hard or soft palate (n = 68), floor of mouth (n = 154), or buccal mucosa (n = 43) between 1975 and 1985 were identified from the records of the Georgia Center for Cancer Statistics. Whites accounted for 71.5% of all cases, and 63.2% of diagnoses occurred among males. The age-adjusted incidence rates (per 100,000 persons) were as follows: white males, 4.9; white females, 2.4; black males, 8.7; black females, 2.3. The age-specific incidence rates for blacks were greatest between the ages of 50 and 69 years, whereas the rates for whites increased progressively with age. Over the time period of this investigation, the age-adjusted incidence rose slightly among blacks, but a small decline was found for whites.

provide a detailed evaluation of the patterns of oral cancer occurrence among residents of metropolitan Atlanta.

### Materials and Methods

The present data were collected by the Georgia Center for Cancer Statistics (GCCS), a population-based cancer registry affiliated with the Surveillance, Epidemiology, and End Results

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(SEER) Program of the National Cancer Institute. A detailed description of the operation of this registry has been provided in earlier reports.<sup>3,4</sup> Since 1975, clinical and demographic information on all new cases of cancer diagnosed in residents of metropolitan Atlanta (Clayton, Cobb, DeKalb, Fulton, and Gwinnett counties) has been collected by the registry. Cases were identified from hospital records, free-standing pathology

laboratories, and death certificates.

For the purposes of this study, eligibility was limited to residents of metropolitan Atlanta with a new diagnosis of invasive squamous cell carcinoma of the tongue, hard or soft palate, floor of mouth, or cheek mucosa between January 1, 1975, and December 31, 1985. All diagnoses were histologically confirmed. In addition, patients with any previous malignancy were excluded from the analysis. The number of patients with non-squamous cell carcinoma was too small to provide meaningful analysis, and therefore such



patients were excluded.

The study period was centered around the 1980 U.S. Census,<sup>5</sup> to allow the most accurate estimates of the size of the source population. Age-specific incidence rates were computed for each of the race and gender subgroups. In addition, race- and gender-specific incidence rates were summarized by direct age adjustment<sup>6</sup> for each of three time sub-intervals, 1975-78, 1979-82, and 1983-85, using Census Bureau estimates of the population for these years, and the age distribution of the 1970 U.S. population as the standard. Additional descriptive analyses were performed using contingency tables and corresponding Pearson chi-square statistics.<sup>7</sup>

## Results

A total of 585 patients were registered during the study period. Cancer of the tongue was by far the most common subsite involved (54.7%), followed by neoplasia of the floor of mouth (26.3%), palate (11.6%), and buccal mucosa (7.4%). The majority ( $n = 418$ ; 71.5%) of patients were white, with blacks accounting for the remainder ( $n = 167$ ; 28.5%) (Table 1). Almost two-thirds of the patients were males. Whites tended to be older than blacks at diagnosis (median age 63.5 years versus 56.0 years, respectively). The

**TABLE 1. Distribution of patients by race, sex and age at diagnosis**

Age Group (years)	Whites				Blacks			
	Male		Female		Male		Female	
	<i>n</i>	(%)*	<i>n</i>	(%)	<i>n</i>	(%)	<i>n</i>	(%)
≤39	10	(4.0)	9	(5.3)	6	(5.0)	4	(8.7)
40 - 49	27	(10.8)	7	(4.1)	23	(19.0)	12	(26.1)
50 - 59	66	(26.5)	41	(24.3)	46	(38.0)	15	(32.6)
60 - 69	82	(32.9)	46	(27.2)	34	(28.1)	9	(19.6)
≥ 70	64	(25.7)	66	(39.1)	12	(9.9)	6	(13.0)
Total	249		169		121		46	

\*Numbers in parentheses are percentages of column totals.

**TABLE 2. Distribution of patients by race, sex and anatomic subsite**

Site	Whites				Blacks			
	Male		Female		Male		Female	
	<i>n</i>	(%)*	<i>n</i>	(%)	<i>n</i>	(%)	<i>n</i>	(%)
Tongue	139	(55.8)	80	(47.3)	74	(61.2)	27	(58.7)
Floor of mouth	62	(24.9)	49	(29.0)	32	(26.4)	11	(23.9)
Palate	31	(12.4)	16	(9.5)	14	(11.6)	7	(15.2)
Buccal mucosa	17	(6.8)	24	(14.2)	1	(0.8)	1	(2.2)
Total	249		169		121		46	

\*Numbers in parentheses are percentages of column totals.

**TABLE 3. Distribution of patients by anatomic subsite and age at diagnosis**

Age Group	Tongue		Floor of month		Palate		Buccal mucosa	
	<i>n</i>	(%)*	<i>n</i>	(%)	<i>n</i>	(%)	<i>n</i>	(%)
≤ 39	23	(7.2)	3	(1.9)	3	(4.4)	0	(0.0)
40 - 49	46	(14.4)	16	(10.4)	5	(7.4)	2	(4.7)
50 - 59	87	(27.2)	52	(33.8)	24	(35.3)	5	(11.6)
60 - 69	88	(27.5)	50	(32.5)	21	(30.9)	12	(27.9)
≥ 70	76	(23.8)	33	(21.4)	15	(22.1)	24	(55.8)
Total	320		154		68		43	

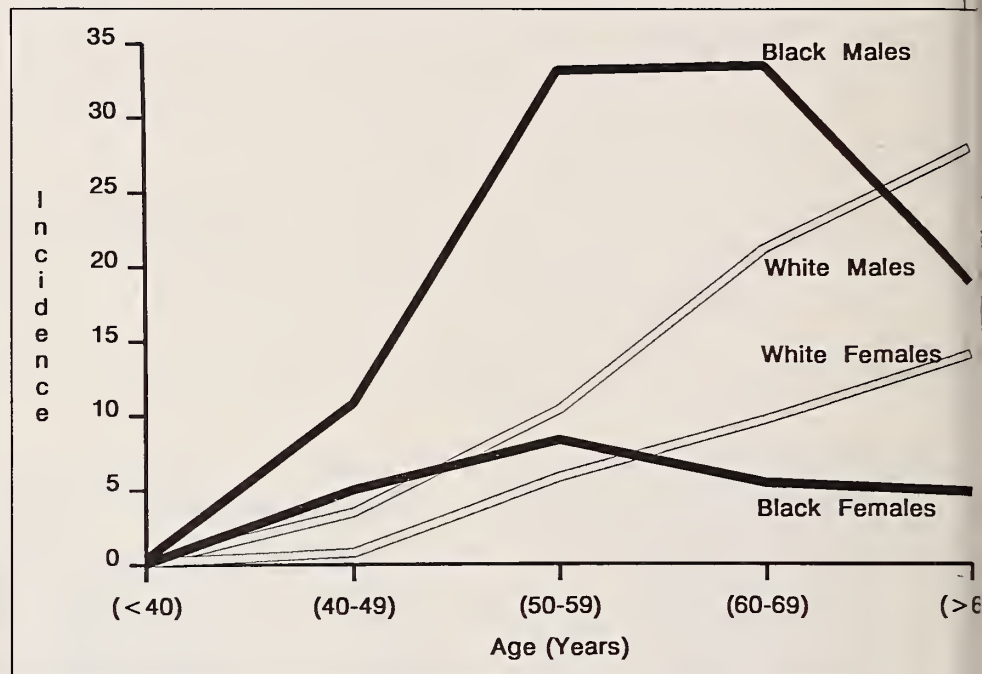
\*Numbers in parenthesis are percentages of column totals.

proportion of patients aged 70 years or older was higher for females than males (33.5% and 20.5%, respectively).

The age-specific incidence rates for each of the race and gender subgroups are presented in Figure 1. In general, the incidence rates tended to increase with age, with a peak between 50 and 69 years for blacks, and a progressive increase with age for whites. Of particular concern was the very high incidence of oral cancer (approximately 33 per 100,000 persons) among black males between 50 and 69 years and among older white males (over 27 per 100,000 persons). The age-adjusted incidence rates per 100,000 whites were 4.9 and 2.4 for males and females, respectively. Among blacks, the age-adjusted incidence rates were 8.7 and 2.3 for males and females, respectively. In other words, after removing the effect of differing age distributions, black males had the highest overall incidence of oral cancer, followed by white males. No racial differential in incidence was found among females.

The distribution of patients by race, gender, and anatomic subsite of involvement is depicted in Table 2. For both males and females, blacks had an elevated proportion of tongue neoplasms. Cancer of the buccal mucosa was extremely rare among blacks, although its occurrence was more frequent among whites. Of special interest was the relatively large proportion of cancers of the buccal mucosa (14.2%) among white females.

The distribution of subsites of oral malignancies by age at diagnosis is presented in Table 3. Clearly, cancer of the buccal mucosa tended to occur among older patients (median age = 72 years), when compared with neoplasms of other subsites (median age = 60 years). Over



half of all cancers of the buccal mucosa occurred in persons 70 years and older, compared with less than one-fourth of other oral malignancies.

In order to examine trends in incidence over time, the total period of observation was divided into three subintervals: 1975 through 1978, 1979 through 1982, and 1983 through 1985. A comparison of age-adjusted incidence rates between the initial and final time periods revealed differences by racial group: increases of 7% and 20% for black males and females, respectively, and decreases of 4% and 26% for white males and females, respectively.

### Discussion

The higher age-adjusted incidence of oral cancer for males compared with females, and for blacks compared with whites in metropolitan Atlanta, is consistent with the national experience.<sup>2,8</sup> Overall, the highest age-adjusted incidence was observed among black males. Also supported by the national data was the general

increase in the age-specific incidence rates with advancing age, except for declining rates for blacks above age 70.<sup>2,8</sup> This decreased incidence among the current cohort of older blacks may reflect a lower exposure to risk factors for oral cancer, such as cigarette smoking, among blacks born in earlier years.

Tobacco smoking and alcohol consumption have been shown to play important etiologic roles in the occurrence of oral cancer.<sup>9,10</sup> In addition, tobacco and alcohol act synergistically, so that persons exposed to both agents have an especially elevated risk.<sup>10-12</sup> Use of tobacco and alcohol are more prevalent among males than females<sup>13-16</sup> and are more common among blacks than whites.<sup>13,14,17</sup> These patterns of use (i.e., higher prevalence of use among groups with elevated risk of oral cancer) further support the potential etiologic roles of these products.

**A**nother public health concern is the recent resurgence in the use of smokeless tobacco.<sup>18</sup>



With increasing restriction of cigarette smoking in public places, more people may resort to the use of smokeless tobacco.<sup>18</sup> An association between the use of smokeless tobacco and cancer of the buccal mucosa has been demonstrated in previous studies.<sup>19,20</sup> The present finding of an elevated percentage of buccal malignancies among elderly white females is consistent with earlier work<sup>20</sup> linking snuff dipping to the risk of oral neoplasia in Southern women.

Another possible risk factor for oral cancer is poor dentition, i.e., ill-fitting dentures or broken teeth that may cause chronic irritation.<sup>9</sup> It has been suggested that the decline in incidence of oral neoplasia among some demographic subgroups may be related to improved dental hygiene.<sup>21</sup>

Contrary to the national experience, the age-adjusted incidence rates among black male Atlantans have not increased substantially over the past decade. Furthermore, declining incidence rates over time have been observed among whites. These temporal trends essentially were unchanged when nonsquamous oral cancers and malignancies of the lip and pharynx were included in the analysis. In the United States, the proportion of smokers has been decreasing consistently since 1965.<sup>22</sup> The consumption of alcohol in this country also has declined since 1980-81.<sup>23</sup> The observed temporal trends in the incidence of oral cancer may be attributed, in part, to the decreasing use of these products in the population.

Although cancer of the oral cavity is relatively uncommon,<sup>2</sup> its propensity toward disfigurement and poor prognosis make this disease appropriate for cancer control interventions. Effective programs directed toward the

prevention, reduction, or cessation of alcohol and tobacco use also should serve to decrease the incidence of oral cancer. The individual physician can play a key role in primary prevention through patient education about the harmful effects of these products.

Additional gains can be made in reducing the impact of oral cancer by the implementation of early detection strategies. The overall 5-year relative survival rate for oral cancer is only about 50%; however, this rate increases to 75% when the disease is diagnosed at the localized stage.<sup>2</sup> It is disturbing, therefore, that overall, only 40% of cases are diagnosed at the localized stage; for blacks, the proportion with localized oral cancer is only 26%.<sup>2</sup> Clearly, there is a need for public education about the signs and symptoms of oral cancer and the benefits of early treatment. Physicians and dentists should incorporate visual inspection for suspicious oral lesions as a routine part of patient evaluation. In addition, screening programs targeted at high risk populations (i.e., older consumers of alcohol and tobacco) would help to identify patients at early stages.<sup>24</sup> Reductions in the incidence and mortality from oral cancer will be sustained only through concerted efforts at both primary and secondary prevention.

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## Restrictive Covenants and Georgia Physicians

Wendy K. Holland

**“A premium should be placed on drafting a restrictive covenant which meets the needs of the employer and does not impose unnecessary prohibitions on the employee.”**

**T**HE USE OF RESTRICTIVE COVENANTS, or, as they are commonly known, “covenants not to compete,” is fairly extensive, and physicians may encounter such restrictions in a number of situations. For example, an established physician needing to employ a second physician to meet the demands of his or her practice may be concerned that the physician employee will work long enough to develop professional relationships with many of the employing physician’s patients and then leave and take these patients with him or her.

Alternatively, a young physician seeking to practice with an established physician in order to further develop his or her skills may be required to sign an

employment agreement which provides that, following termination of the employment arrangement, the employee will be unable to practice medicine in the same community for some specified period of time.

### Overview of Georgia Law

Over the years, the Georgia courts have developed specific rules which they use to analyze the validity of restrictive covenants. Although it is well established that parties are free to contract on any terms and about any subject matter in which they have an interest, certain contracts may be in contravention of the public policy of the State of Georgia and thus unenforceable. Generally, contracts which tend to defeat or lessen competition are contrary to public policy.<sup>1</sup> Restrictive covenants are deemed by the courts to be “partial restraints of trade,” and are thus enforceable only under certain conditions.<sup>2</sup>

Georgia courts have distinguished between restrictive covenants ancillary to employment contracts and restrictive covenants ancillary to agreements for the sale of a business, the latter being more likely to be upheld by the courts. The primary reason for this more lenient judicial analysis of restrictive covenants with respect to the sale of businesses is that a contract of employment inherently involves parties of unequal bargaining power; on the other hand, a contract for the sale of a

business interest is far more likely to be entered into by parties on equal footing.<sup>3</sup> As described below, restrictive covenants in professional partnership agreements ordinarily are viewed as involving equal bargaining power between the parties, and thus are more likely to be upheld.<sup>4</sup>

Noncompete clauses in connection with employment are normally enforceable if they restrict post-employment activities in a manner determined to be reasonable under the circumstances. This means that the covenant be in writing, be supported by consideration, and be reasonable as to scope, territory and time. In the past, the courts have applied this test rather mechanically, although several recent cases appear to relax this mechanical approach, in certain circumstances.<sup>5</sup>

### Enforceability of Restrictive Covenants in Employment and Partnership Agreements Involving Medical Practitioners

As indicated above, one condition that must be established in order successfully to enforce a restrictive covenant involves the scope of the proscribed activities; this must be set out in the employment or partnership agreement with specificity. In respect to medical practitioners, it is well settled that this may be accomplished if the restrictive covenant prohibits an employee from “engaging in the practice of medicine or surgery”

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after termination of his or her employment. The primary justification for this is that the term "practice of medicine" is defined under Georgia law<sup>6</sup> and therefore serves to inform the employee of the specific activities in which he or she cannot engage after termination of employment.

The second condition which must be established in order to enforce a restrictive covenant involves the territory in which the employee agrees not to practice subsequent to the termination of employment. The reasonableness of the territory will obviously depend on the facts of the particular case. For instance, the court in one Georgia case determined that a restrictive covenant which prohibited the employee from practicing medicine within a 50 mile radius of Forest Park, Georgia, was reasonable and enforceable.<sup>7</sup> Also, a restrictive covenant was held to be enforceable where the former employee agreed that he would not practice ophthalmology within a territory composed of Fulton, Clayton, Cobb, DeKalb and Gwinnett counties, despite the fact that 95% of his patients came from this five county area.<sup>8</sup>

Finally, a covenant must be reasonably limited in duration, although there is no per se reasonable or unreasonable time limit. This condition will also depend for the most part on the particular factual situation involved. For example, it has been held that restrictive covenants which impose two- and three-year limitations,

respectively, on the establishment of a competing practice, were reasonable.<sup>9</sup> On the other hand, restrictive covenants which prohibited the establishment of a competing practice for the life of the employed physician or for an indefinite period have been struck down as being unreasonable and therefore in contravention of public policy.<sup>10</sup>

## How to Properly Contract

The most important consideration for those physicians who will be employing other physicians is not to be overreaching. In other words, there is no reason to impose a restrictive covenant on an employee which prohibits the employee from acting in "any capacity" when a restrictive covenant prohibiting the "practice of medicine or surgery" will do. Similarly, a restrictive covenant seeking to prevent the employee from practicing within a broad range of territory over a long period of time is not necessary if a lesser territory or time will suffice in order to protect the employer physician's legitimate interests.

From the prospective employee's perspective, some thought should be given to the practical ramifications of the restrictive covenant, in terms of the territory and the time limitations of such prohibition. Indeed, it is oftentimes helpful for a prospective employee to draw on a map the particular area in which he or she may not practice

following termination; by doing so, the employee can clearly see the particular area in which he or she will be unable to practice following termination.

In sum, restrictive covenants in employment and partnership agreements, if drafted properly (i. e., specifying with particularity the prohibited activity and containing reasonable constraints in terms of time and territory) are likely to be enforced against employed physicians. On the other hand, if overly broad or vague, a restrictive covenant is not likely to be enforced, and the employing physician will thus lose the protection which may have served as a primary inducement to enter into the employment agreement. Consequently, both from the employer's position and from the employee's position, a premium should be placed on drafting a restrictive covenant which meets the needs of the employer and does not impose unnecessary prohibitions on the employee.

## Notes

1. O.C.G.A. §13-8-2(a)(2) (1982).
2. See, generally, Annotation "Validity and Construction of Contractual Restrictions on Right of Medical Practitioners to Practice, Incident to Partnership Agreement," 62 ALR 3d 970 (1975).
3. *Watson v. Waffle House, Inc.*, 253 Ga. 671, 324 S.E.2d 175 (1985).
4. *Rash v. Toccoa Clinic Medical Associates*, 253 Ga. 322, 320 S.E.2d 170 (1984).
5. See, e.g., *Watson v. Waffle, Inc.*, *supra*.
6. O.C.G.A. §43-34-20(3) (1984).
7. *McMurray v. Bateman*, 221 Ga. 558, 144 S.E.2d 345 (1965).
8. *Railford v. Kramer*, 231 Ga. 757, 204 S.E.2d 171 (1974).
9. *Railford v. Kramer*, *supra*; *Rash v. Toccoa Clinic*, *supra*.
10. *Rakestraw v. Lanier*, 104 Ga. 188, 30 S.E. 735 (1988).

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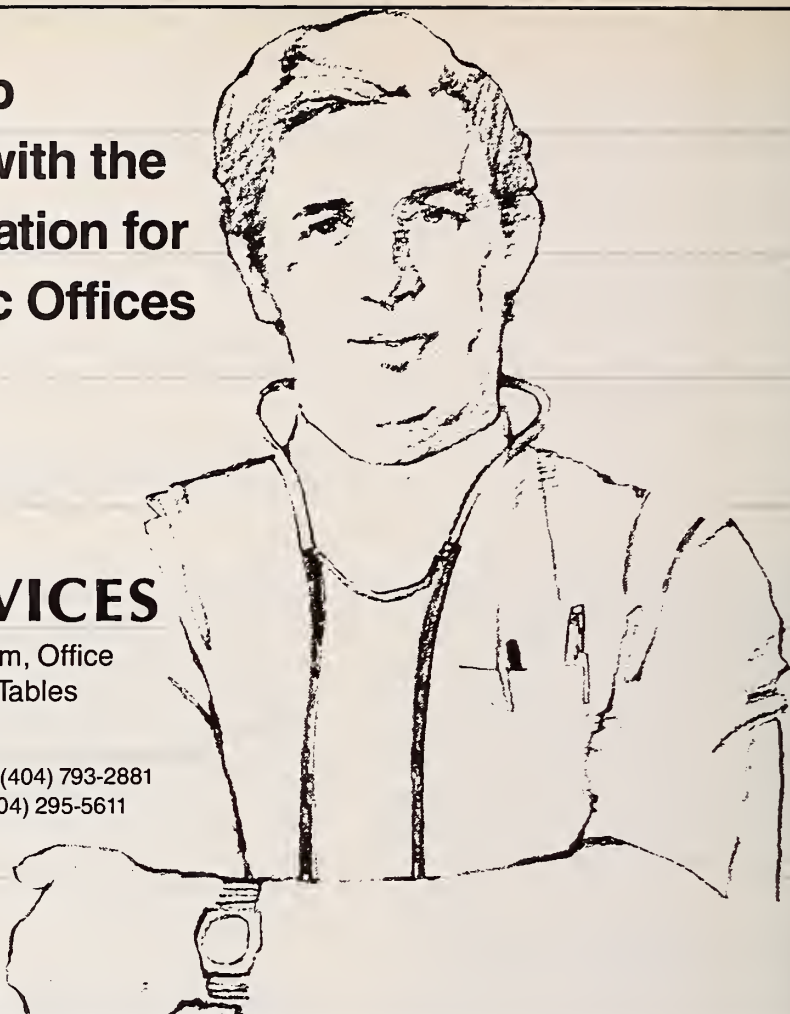
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**BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.**

1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure; hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function; potassium-losing nephropathy; and certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control mild cases. In more severe cases supplementation with potassium salts may be indicated.

### CONTRAINDICATIONS

Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see OVERDOSAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

### WARNINGS

**Hyperkalemia** (See OVERDOSAGE).

In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

### Interaction With Potassium-Sparing Diuretics

Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

### Gastrointestinal Lesions

Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

### Metabolic Acidosis

Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

### PRECAUTIONS

#### General:

The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

#### Information for Patients

Physicians should consider reminding the patient of the following:

To take each dose without crushing, chewing, or sucking the tablets.  
To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.  
To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.

To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

#### Laboratory Tests

Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

#### Drug Interactions

Potassium-sparing diuretics: see WARNINGS.

#### Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in animals have not been performed.

#### Pregnancy Category C

Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproductive capacity. Slow-K should be given to a pregnant woman only if clearly needed.

#### Nursing Mothers

The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

### Pediatric Use

Safety and effectiveness in children have not been established.

### ADVERSE REACTIONS

One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

### OVERDOSAGE

The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 ml/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

### DOSE AND ADMINISTRATION

The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

**Note:** Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

### HOW SUPPLIED

Tablets—600 mg of potassium chloride (equivalent to 8 mEq) round, buff colored, sugar-coated (imprinted Slow-K)

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# MR UPDATE

## MRI Advances the Detection of AVM's

### BRAIN EXAMINATION

**HISTORY:** A 52 year old man had two small right occipital hemorrhages, 18 months apart. After resolution, negative studies included two cerebral arteriograms and contrast CT scans.

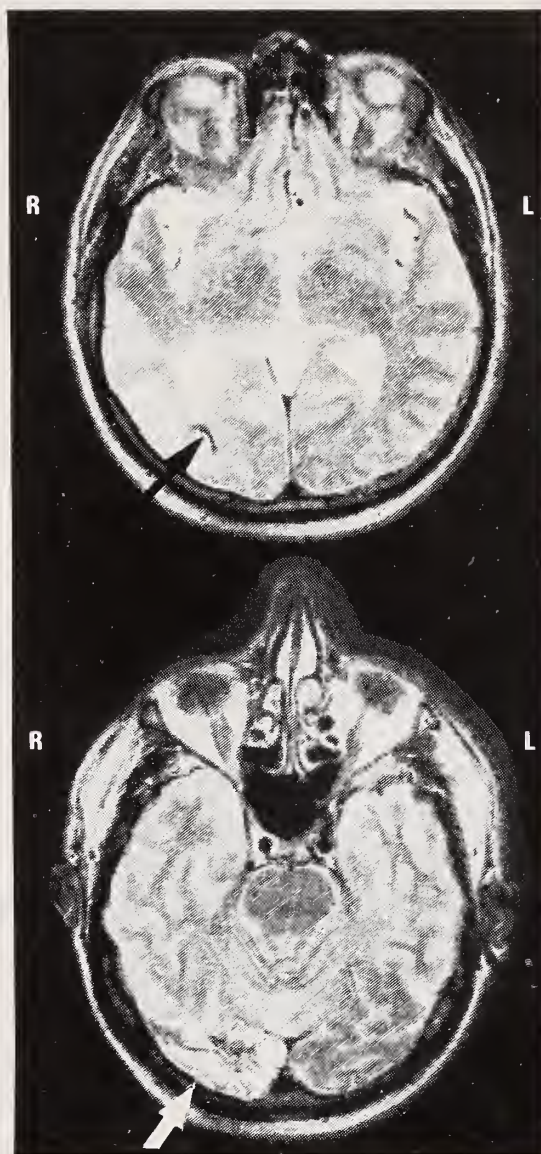
**SCAN:** Several dark curvilinear structures, evidence of the flow void phenomenon, indicate abnormal vasculature in the right occipital lobe. Associated high signal intensity of adjacent white matter is compatible with edema, hemorrhage, or gliosis. Together these findings are consistent with occult arteriovenous malformation (AVM).

**MRI HIGHLIGHTS:** MRI is highly sensitive for AVM's which are otherwise occult by arteriography or CT scanning. These may be found in patients with spontaneous hemorrhage, seizure disorder, or other clinical presentations. In addition, the sensitivity of MRI for intracranial hemorrhage is being increased through the use of new partial flip imaging techniques. Refinements in signal processing, surface coils, and other techniques continue to expand the clinical indications of MRI. Because of its sensitivity, safety, and patient comfort, MRI is the screening technique of choice for most CNS abnormalities.

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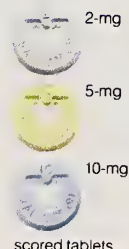
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Sorter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. *N Engl J Med* 1976;294:687-90.

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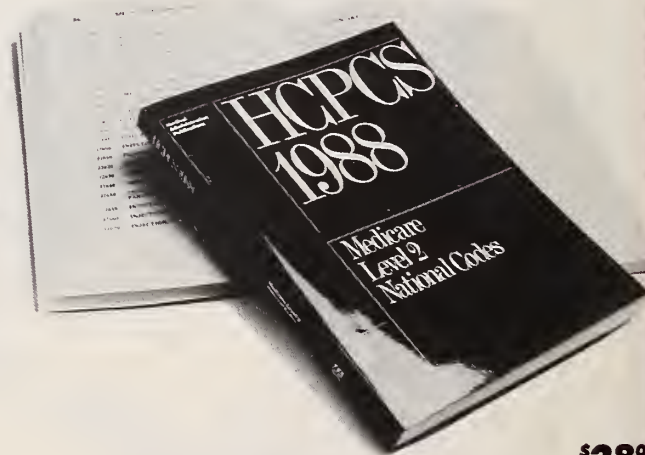
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**COVER**

On the cover, a woman climbs the stairs to the Central Health Center at Central Presbyterian Church across from the State Capitol in Atlanta. The Center provides medical care to disadvantaged people according to the patient's ability to pay. In several articles in this issue, we focus on medical care for the disadvantaged and its effects on hospitals, insurance companies, and society as a whole.

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60-64	\$211.00	\$498.00

\*A+ Rated" Carrier  
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AGE	EMPLOYEE	FAMILY
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45-49	\$ 59.00	\$142.00
50-54	\$ 70.00	\$155.00
55-59	\$ 84.00	\$169.00
60-64	\$101.00	\$186.00

\*The "A + Rated" carrier's premiums would be slightly higher in the Atlanta area. Rates and contracts are subject to change. A number of options are available including Maternity, Prescription, Dental, etc. at additional premiums. All premiums are subject to underwriting acceptance.

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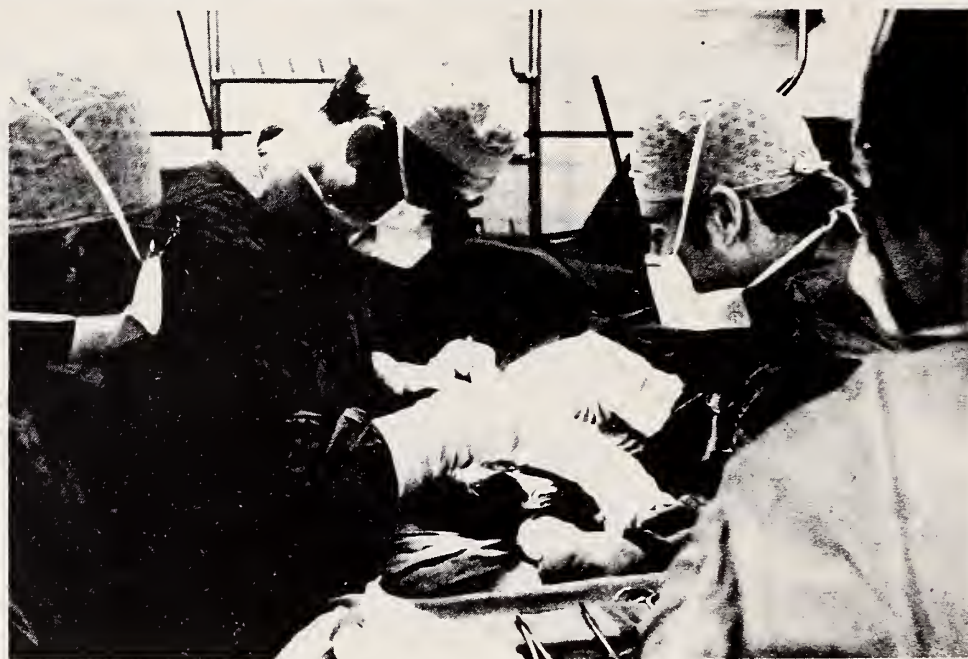
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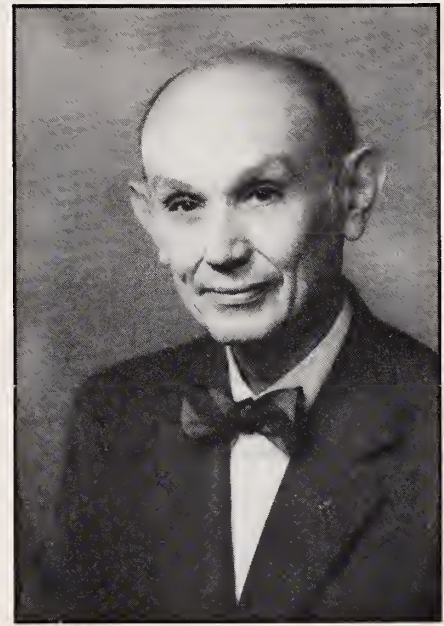
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*Joseph P. Bailey, Jr., M.D.*

**T**HE AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA has received national recognition for its positive relationship and contribution to our state medical association. Mrs. William C. Collins (Jan), President of the Auxiliary, will make presentations at the national auxiliary meeting in October, 1988, and again at the AMA Leadership Conference in February, 1989, in which she will discuss the role of the Auxiliary in relationship to organized medicine through state medical societies. I am privileged to have been asked to participate with her.

Their signal honor and recognition is another tribute to the vital service of our auxiliary to medicine. We are indeed fortunate to have such an excellent organization as ours and to be the recipient of their ongoing involvement, tremendous effort, and great vitality in support of the betterment of mankind.

Please be certain to thank them for what they are and what they do.

*Joseph P. Bailey, Jr.*

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Dalrymple, Barbara J. — Bibb —  
(Active) 777 Hemlock St., Macon  
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Dripchak, Philip O., Orthopaedics  
— DeKalb — (Resident) 864  
Sycamore Dr., Decatur 30030

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Gynecology — Georgia Medical  
— (Resident) P.O. Box 23089,  
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31602

Woolery, William A., Family  
Practice — Peachbelt — (Active)  
205 Dental Dr., Warner Robins  
31088

## PERSONALS

*Carroll-Haralson CMS*

MCG graduate **Michael Deal, M.D.**, recently opened a new pediatric practice in Carrollton.

*Dougherty CMS*

**John Schilling, M.D.**, has opened an office in Henry General Professional Building B to practice obstetrics and gynecology. Dr. Schilling previously practiced 3 years at Fort McClellan in Alabama and 3 years in Greenville, Mississippi.

*Lumpkin CMS*

**Kathleen A. Mahvi, M.D.**, was recently appointed to the Hamilton Medical Center staff in Dalton. Dr. Mahvi received her medical degree in anesthesiology from the University of Kansas School of Medicine.

*Muscogee CMS*

**Ben A. Grigsby, M.D.**, **James H. Johnson, M.D.**, and **Walton Sumner, M.D.**, recently graduated from the 3-year family practice residency program at The Medical Center in Columbia. Special honors went to Drs. Grigsby and Sumner.

*Sumter CMS*

Radiologist **Michael H. Baldwin, M.D.**, recently joined the staff at Sumter Regional Hospital in Americus. He is a graduate of the Medical University of South Carolina.

*Whitfield-Murray CMS*

**Frederick E. Dixon, M.D.**, and **Norman D. Hardman, Jr., M.D.**, were recently appointed to the Hamilton Medical Center staff in Dalton. Dr. Dixon, a cardiologist, is a graduate of the University of Virginia Medical School. An internist, Dr. Hardman received his medical degree from MCG.

## QUOTES

*Many persons might have attained to wisdom had they not assumed they already possessed it.*  
SENECA

*A real friend is one who walks in when the rest of the world walks out.*  
WALTER WINCHELL

*Little progress can be made merely attempting to repress what is evil. Our great hope lies in developing what is good.*  
CALVIN COOLIDGE

## September

26-29 — *Atlanta: Advanced Demonstrations in Percutaneous Transluminal Angioplasty XX.* Category I credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

26-30 — *Atlanta: Modern Methods of Diagnosing and Treating Diabetes Mellitus and Its Complications.* Category I credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

27-28 — *Atlanta: Public Health Service Policy on Humane Care and Use of Laboratory Animals.* Category I credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

28-29 — *Atlanta: Georgia Chapter of the American Academy of Pediatrics Fall Meeting.* Contact Executive Secretary William Mankin, 4059 Land O'Lakes Dr., Atlanta 30342.

28-30 — *Unicoi State Park: Looking Ahead: Caring for Georgia's Aging Population. Seventh Annual Conference of the Georgia Rural Health Association.* Category I credit. Contact Pauletta Graves, Office of CME, Morehouse School of Medicine, 720 Westview Dr., Atlanta 30310. PH: 404/752-1629.

29-30 — *Atlanta: Stress and the Heart: Risks and Recovery.* Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

30 — *Atlanta: Recent Advances in Clinical Oncology.* Category I

credit. Contact David Gordon, M.D., 1365 Clifton Rd., Atlanta 30322. PH: 404/727-6761.

30-Oct. 1 — *Augusta: Current Concepts in Organ and Tissue Donation and Transplantation.* Category I credit. Contact Div. of Cont., Ed., MCG, August 30912. PH: 404/721-3967.

## October

5 — *Atlanta: Joseph S. Skobba Symposium (Psychiatry).* Category I credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

6-9 — *Sea Island: Georgia Orthopaedic Society.* Category I credit. Contact David Apple, Jr., M.D., 1938 Peachtree Rd., Ste. 710, Atlanta 30309. PH: 404/352-2234.

7-9 — *Atlanta: Annual Meeting of the Georgia Gastroenterologic Society.* Category I credit. Contact Steven Morris, M.D., 20 Linden Ave., Suite 500, Box 27, Atlanta 30365. PH: 404/881-1094.

10-14 — *Atlanta: Magnetic Resonance Imaging.* Category I credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

10-14 — *Atlanta: Modern Methods of Diagnosing and Treating Diabetes Mellitus and Its Complications.* Category I credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

11-16 — *Atlanta: American Society of Internal Medicine Annual Meeting.* Category I credit. ASIM, 1101 Vermont Ave., Ste., 500 Washington, D.C. 20005. PH: 202/289-1700.

12 — *Helen: Diagnosis and Management of HIV-Infected Patients.* Category I credit. Contact Gail Rogers, RN, 743 Spring St., Gainesville 30501-3899. PH: 404/535-3495.

13-14 — *Atlanta: Clinical Issues in Renal Transplantation.* Category I credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

13-14 — *Atlanta: Compelling Choices: Allocating Health Care Resources.* Sponsored by St. Joseph's Hosp. of Atlanta. Category I credit. Contact Joan Rixom, Educational Ser. Dept., St. Joseph's Hosp., 5665 Peachtree Dunwoody Rd., Atlanta 30342. PH: 404/851-7027.

20-21 — *Atlanta: Interventional Radiology for Physician's.* Category I credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

21 — *Atlanta: SLE Symposium — Update 1988.* Category I credit. Contact Andriette Ward, Office of CME, Morehouse School of Medicine, 720 Westview Dr., Atlanta 30310. PH: 404/725-1770.

21-22 — *Atlanta: Managing Preterm Labor & Electronic Fetal Monitoring.* AMA Category 1 and ACOG cognate credits. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

24-28 — *Atlanta: Modern Methods of Diagnosing and Treating Diabetes Mellitus and Its Complications.* Category I credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.



### Health Care Highlights of 1988 Democratic Platform

While upholding Democrats' traditional emphasis on health care issues, the 1988 Democratic Platform does not call for national health insurance — for the first time since 1948.

The following are highlights of the final document:

"We believe that all Americans should enjoy access to affordable, comprehensive health services for both the physically and mentally ill, from prenatal care for pregnant women at risk to more adequate care for our Vietnam and other veterans, from well-baby care to childhood immunization to Medicare; that a national health program providing federal coordination and leadership is necessary . . . ; that quality, affordable, long-term home and health care should be available to all senior and disabled citizens . . . that every family should have the security of basic health insurance; and that the HIV/AIDS epidemic is an unprecedented public health emergency requiring support. . . ."

### Catastrophic Law Could Cut PPS Payments

Hospitals may find themselves saddled with lower DRG rates than appropriate under the law as a result of the implementation of Medicare catastrophic-illness insurance benefits, according to James Houdek, the AHA's director of regulatory affairs.

PPS rates currently are reduced to compensate for hospitals' receipt of patients' deductibles and coinsurance payments. But the Medicare Catastrophic Coverage Act of 1988, whose Part A benefits take effect Jan. 1, 1989,

requires beneficiaries to pay only a single annual deductible and eliminates daily copayments for inpatient care. The law directs the HHS secretary to consider, "when appropriate," adjusting hospital payments to account for the lower DRG payments and the lack of incoming copayments.

### CEOs/Med Staff/Boards Work Well, According to Survey

Response from more than 1800 hospitals to a recent survey by the JCAHO found high levels of overall satisfaction with the working relationships of CEOs, governing boards, and medicals. At least 80% of the respondents to each group said that they were satisfied with the relationships.

The most common disagreements identified were in the areas of hospital operations and services. There is evidence that hospitals are increasing the level of communication among the three groups. For example, 66% reported that at least one medical-staff member has a vote on their hospitals boards; 68% of the facilities reported that their CEOs are represented on medical staff executive committees.

### Nursing Home Data Released Criticized

HCFA's impending data release on the nation's more than 19,000 nursing homes came under sharp attack last week in a meeting with consumers and health care providers. Unlike last December's release of hospital-specific mortality data, in which HCFA applied a new statistical model to generate information, HCFA now plans to repackage select resident-characteristic information and 32 of nearly 500

nursing-home performance indicators that are already available to the public.

Some critics charged that HCFA's proposed information-release package fails to adequately inform consumers of facility-specific characteristics that could affect patient care. Some long term care facilities, especially hospital-based nursing homes, serve a greater proportion of "heavy care" residents who require more intensive services.

### Experts List Strategies for Troubled Hospitals

It's critical for hospital executives to recognize the early warning signs of financial trouble in their institutions so they can develop strategies for survival. Distress signals that need to be examined range from negative trends in financial ratios to low morale among employees and medical staff members. Non-financial measures which often signal trouble are dissension within the medical staff, high turnover of managers, difficulty in contracting with managed care providers, and the deteriorating appearance of the facility.

Those strategies for survival include:

- Improving financial status by implementing incentive compensation plans and trimming employee benefits;
- Teaming up with others, either through a merger with another institution or through joint ventures with physicians;
- Converting hospital space to new uses;
- Buying time until reimbursement and competitive conditions improve . . . ;
- Closing the facility.

*This Department is sponsored by the Georgia Hospital Association*

Dear Editor:

**T**HE ARTICLES by Kaplan, Jones and Biel and by Koplan and Jones in the July issue of the *Journal* were thought-provoking. Certainly, physicians should consider the social and health effects of a nuclear weapons exchange.

There has been a spate of articles appearing in the medical literature in recent years pertaining to nuclear weapons/war. It troubles me that they tend to reveal a persistent bias. Most authors either seem to imply (or to state openly) that disarmament is *the* solution to nuclear anxiety, and that physicians should jump on the bandwagon of the Physicians for Social Responsibility (or other similar organizations). Now, I realize that physicians would prefer to ignore issues of ideology. Ideology doesn't seem to mix very well with medicine. And yet it remains clear to me that the *other* chief agent in disarmament issues has repeatedly demonstrated an ideology more consistent with tyranny than glasnost (which could be more form than substance). To put all our eggs in the disarmament basket, relying upon those who have shown themselves aggressors, seems rather foolish to me.

Or let us just simply suppose that arms negotiators never quite manage to bring off the *total* obliteration of nuclear weapons from the world. (This seems more than conceivable to me.) What then? What about the "forgotten" preventative?

Setting aside strategic defense measures (though perhaps we should not), what about plans for a nationwide blast shelter and decentralized food storage system

envisioned by President Kennedy and then scrapped by his successors? Opponents of such low-tech defensive measures usually dismiss them with a snort as "inadequate and impractical" (to quote Koplan and Jones.) But *are* they? Has there been a disinformation campaign aimed at these measures? They've never been *proven* inadequate anymore than negotiated disarmament has been proven adequate. There are, it may surprise some readers to learn, scientists and physicians who believe such a shelter system *would* work.<sup>1,2,3</sup> And if a blast shelter system is such an unworkable idea, why have the Soviet Union, the Peoples' Republic of China, and peace-loving, neutral Switzerland invested so heavily in their own extensive food and shelter systems?

Truly, the prospect of even a limited nuclear exchange is very troubling. But are there measures beyond disarmament negotiations with the Soviet oligarchy to which we should be giving serious attention? Personally, if the "worse" should actually happened, when the warning sirens sound (*if* they work), my family and I would, I think, prefer the *chance* a shelter system *might* provide to a collection of anti-nuclear-weapons books, articles and videotapes.

Sincerely yours,  
James L. Fletcher, Jr., M.D.  
Assistant Professor  
Department of Family Medicine  
MCG

## References

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8204, Ft. Worth, Texas 76124), 1986.

2. Orient JM, Disaster preparedness: an international perspective. *Ann Int Med* 1985;103:937-940.

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Dear Editor:

**T**hanks very much for your very thoughtful article ("On Death and Euthanasia") in the *MAG Journal*, July 1988. The topic is one of vital interest to me and appropriately in my opinion to all physicians. Thanks for sharing your thoughts about this.

Very best regards,  
Joseph H. "Skoot" Dimon, III,  
M.D.  
Orthopedist, Atlanta

Dear Editor:

**D**r. Roger's article on Relative Value Scales (RVS) in the July, 1988, (*Journal*) issue could not have been more timely. He cites historical facts where physicians' disunity made certain changes (better or worse?) possible. It is this absence of unity that has brought upon this profession the evils that plague us today. Dr. Rogers, like a seer, points out the dangers of not joining our ranks and speaking with a unified voice. As physicians, we are all committed to the "Hippocratic Oath" — hence our beliefs ought to be the same.

Sincerely,  
Jaydey R. Varma, M.D.  
Assistant Professor  
Department of Family Medicine  
MCG



Dear Editor,

Three cheers for "On Death and Euthanasia" in the July *JMAG*. You'll probably be hung in effigy; but when my time comes, I hope someone will be as considerate of my suffering as they are of their dog's.

Sincerely yours,  
Frank Matthews, M.D.  
Pathologist, Atlanta

Dear Editor:

I was reading the article ("On Death and Euthanasia") in the July, 1988 Editor's Corner of the *Journal*. Perhaps you will find this quotation from James Rachels interesting and if read with understanding, it really is appropriate.

I am not a proponent of euthanasia. However, I think death with dignity can be accomplished by concerned, compassionate physicians when there is no other alternative. This does not mean giving drugs to produce ventricular fibrillation or any of those matters, but there are many ways to make one's terminal condition as appropriate as when we were born.

*"If it is for god alone to decide when we shall live and when we shall die, then we 'play god' just as much when we cure people as when we kill them."*

—JAMES RACHELS IN *The End of Life*  
OXFORD UNIVERSITY PRESS

Sincerely,  
Francis W. Coleman, M.D., P.C.  
Internist, Valdosta



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# Quiet Thoughts

## A Fresh Awareness

**T**HE DIAGNOSIS OF A GROWING fibroid uterus is enough to shake any young practicing female obstetrician-gynecologist. The prospect of surgery looms directly ahead. So many questions about leaving the practice for a few weeks. Will my patients understand? Will they feel forsaken? Who will do the surgery? Now, there's the clincher!

After much deliberation I chose a fellow whose practice antedates my birth. His reputation of fast-recovery hysterectomy caught my attention. I was somewhat shocked when his nurse used the traditional form of sheet draping during my preoperative examination. Here was a guy who had developed a fascinating and innovative technique of hysterectomy — the most common and well known surgery in gynecology — who still used the old fashioned draping technique. What an entertaining irony!

After the surgery and a smooth, almost pain-free recovery, I pause to thank my doctor, a physician who cared enough to devise a new way of performing an old procedure for the sake of the patient. Since having this experience as a physician-patient, I have a fresh awareness of what it really means when a doctor truly inconveniences him or herself for the benefit of the patient. The clampless technique of hysterectomy requires great precision, agility, and meticulous consideration of detail. It goes beyond the "call of duty." I for one shall be forever grateful to an old fashioned doctor with a new technique.

*Name withheld by request.*

*We invite contributions to this Department. Please send them c/o the Journal, 938 Peachtree St., Atlanta 30309.*



## On Poverty

**T**HE ADOLESCENT NOW GROWN to manhood could still hear, in the quietness of the night, the thundering staccato of his heart as he walked the two flights of stairs in the chemistry building at the little Methodist college. On the third floor were boxes where one found the recently graded examination papers marked so carefully by the professor, "good," or "you can do better." Marked in any manner whatever, he would have settled for simply a decision to end the doubt generated by the testing — to quiet the pounding of his heart and bring to rest the sweating palms.

There was doubt that the monumental task of enduring medical school, and beyond that, the awesome responsibility of practicing medicine, were ones which he was equipped to handle. Effort prevailed if not joined by native talent, and the doubt subsided. It was replaced, the doubt that is, by other uncertainties. He questioned the adequacy of a marriage, of being a good parent, of going into debt. He was then assailed by a myraid of questions arising from the unknown which lay ahead.

How would he react when the first patient died, not of "natural and unpreventable cause," but simply because of his own lack of

knowledge, talent, or effort — died from the frailties of his own human limitations? Had his restless heart been calmed and the sticky palms been cooled only to lead him to the edge of an abyss before which he could only cower?

And so it came, that test, and so followed the triumph. He had been told that, "medicine is a hard mistress. She gives the test first and the lesson afterwards." But he had survived. The test had dwindled for the time. But would he be forever tested? Would it forever be required of him that the answers be given before the lessons? Would it never end, this eternal challenging of his ability to survive?

**A**nd so it still persisted, those many years since the days of the roiling, pounding chest. The last uncertainty lurked menacingly outside the comfort and safety of the protective walls that had risen about him from past doubts conquered. How would he react to abject poverty?

"Me? In a soup line. Heaven forbid!"

"Me, on Medicaid? Oh, my God!"

"Me. Without my Cadillac, my country club, yacht club, mutual funds. Oh, Heaven, protect me!"

In those long, dark hours of the night came once again the pounding and the sweating.

**A**nd so we talk this month of poverty — of indigency. We talk of the provision of health care to those of us not able to pay in kind for that care. Our attention is focused on those who by design or fate find themselves enmeshed not only in the problems of each of our lives but also burdened with the lack of resources or talent to cope with those problems.

We talk of those whom Kipling spoke of:

*"Others may sing of the wine and  
the wealth and the mirth,  
The portly presence of potentates  
goodly in girth;  
Mine be the dirt and the dross,  
the dust and scum of the earth!  
Their's be the music, the colour,  
the glory, the gold;  
Mine be a handful of ashes, a  
mouthful of mould.  
Of the maimed, of the halt and  
the blind in the rain and the  
cold —  
Of these shall my songs be  
fashioned, my tales be told.  
Amen."*

(A Consecration)

CRU

## Our Boneyard Industry

Robert E. Smith, M.D.

**‘We ask families to tell us whether we should let someone die. Why don’t we just advise them of what treatment we think is advisable, explaining the consequences of our treatment plans and gaining their approval, as we do with all other medical activities and decisions?’**

**I** HAVE JUST RETURNED from a nursing home where I visited a poor, elderly lady who, if not technically brain dead, is brain debilitated to the point of a mere physiologic existence level. She can only breathe and function reflexively with no meaningful thought, sensory, or motor activity. She’s had a tracheotomy, and food is being pumped into her stomach via a nasal tube. The liquid “nourishment” causes diarrhea which contaminates the huge decubitus ulcers on her back and hips that are so deep the bones are exposed. Her urine output is maintained by intravenous fluid and drugs, so she will not become uremic and gain graduation to a better existence! Her temperature elevations (usually from terminal bronchopneumonia) are controlled by antibiotics.

This lady is in a “boneyard institution” — a nursing home, where the old medical saying, “Don’t let them die on my time” has changed to “Don’t let them die!” Is this description strong stuff? Shocking? Deplorable? Inhuman? It most certainly is!

As a physician committed to serving people from birth to death for 40 years, I am appalled to see the progressive development of

man’s inhumanity to man in this field. Almost the only way you can get your carcass to rest today is to have an irreversible cardiac arrest or be declared brain dead. Before these limits are reached, patients are often abused, tortured, experimented upon, subjected to litigation for and against, and the pawns in a sinful and shameful social system that has lost its humanity and its morals.

**W**e ask families to tell us whether we should let someone die. Why don’t we just advise them of what treatment we think is advisable, explaining the consequences of our treatment plans and gaining their approval, as we do with all other medical activities and decisions. We have been blessed with education and skills to use wisely not to promote the degradation of our patients in the boneyards.

The legal profession cannot be depended upon to exert a significant brake on these trends. Some nursing homes are refusing to care for skilled care patients. Public hospitals, such as Floyd Medical Center, are dumped on and ignored as they try to cope with these tragic and cruel circumstances. Read an article in the *New England Journal of Medicine* (May 5, 1988) on uncompensated care. It is not only charity that is involved.

Consider these facts: The

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Dr. Smith Director of Family Practice at Floyd Medical Center, 7 Professional Court, Rome, GA 30161. Send reprint requests to him.



patient described above had been in Floyd Medical Center for 123 days at an accumulated cost of \$89,609! Medicare DRG's said she should have only been in the hospital for 5.6 days and at a cost of \$2,427. This patient actually also had private insurance but it would not pay more than the DRGs approved. Since the nursing homes would not accept her, she stayed in the hospital for an extended length of time — a part of uncompensated care if you will, that the public is not aware of.

Other factors complicate this situation, such as the states' rules about who is entitled to Medicaid funding for skilled and intermediate care and the level of funding in nursing homes. Pay scales for nursing home personnel are very low, and skilled personnel are scarce. Finding kind people who will give loving care to these unfortunate souls is often difficult. Doctors are resigning from positions in the nursing homes as medical directors or even giving any care at all. A family physician can expect to receive \$12 for one call a month and to be on call to that patient 24 hours a day, 7 days a week. The stupidity and grossly ridiculous nature of the situation compounds!!

**B**ut let's get back to the nature of our social fabric and address the issues of life and

## **‘Why can't the art of medicine be applied to the dying process as well as the birthing process?’**

death and the practical implications of our national culture and philosophy.

Why can't the art of medicine be applied to the dying process as well as the birthing process? Why do I, as a competent, caring physician, have to be afraid to practice open and honest medicine? The following is part of the answer to these questions:

1. People are afraid of death! They have no comprehension or philosophy to deal with the subject!
2. Advancing technology has promised too much and now evades the physician's control; or if they attempt to bring about some control they face ruin and disgrace via malpractice suits.
3. The social institutions and the medical care system have failed to educate and assist the public to put all of these factors in proper perspective and develop rational approaches to these problems. And so, the parade to the boneyards increases. The present situation is intolerable. It is not

only inhuman, but it is crippling our families, strangling our health care system, and bankrupting our economic resources. Let us change the course of the parade to one of life and an honorable death with dignity.

## **‘We must advocate compassion and death with dignity for our elderly. To do less is indeed intolerably cruel.’**

**B**efore I close, and before the epithets of righteous indignation start to fly, let me say that there are many honest, sincere and moral attorneys, physicians, hospital and nursing personnel, and above all, families who are genuinely concerned about these problems, but they don't seem to have a champion, someone to say these caregivers have had enough! We must all rise out of slovenly apathy and give them support and the strength of moral persuasion. We cannot tolerate this drain on our social, moral, and financial resources any longer! We must advocate compassion and death with dignity for our elderly. To do less is indeed intolerably cruel. ■

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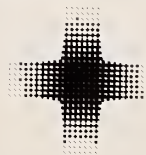
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NOVEMBER 11-13, 1988  
RITZ-CARLTON BUCKHEAD  
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This fall, the Scientific Assembly of the Medical Association of Georgia will again meet in Atlanta at the Ritz-Carlton Buckhead Hotel. Our scheduled dates are November 11-13 (Friday-Sunday). Nine specialty programs will be presented during the weekend, each of which will be accredited for AMA Category 1 hours and other specialty credit designations.

Program chairs for the 1988 MAG Scientific Assembly, responsible for arranging these excellent CME sessions, are:

## ALLERGY

*Allergy and Immunology Society of Georgia*

W. Ronald Tipton, M.D., Atlanta

## CHEST DISEASE

*Georgia Thoracic Society*

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## NEUROLOGY

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Mark A. Kozinn, M.D., East Point

## NEUROSURGERY

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Daniel Barrow, M.D., Atlanta

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## OTOLARYNGOLOGY

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## Registration

Registration for the Scientific Assembly allows a physician to attend any and all CME Programs held during the weekend. To register for these scientific meetings, please complete the registration form inserted in this Journal, detach it from the hotel reservation form, and mail it with your registration fee to the MAG office.

## Registration Fees

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### The Weekend at a Glance

Complete details for all specialty programs will be printed in next month's *Journal*. For now we attach an overview of the Scientific Assembly weekend.

### For More Information

Please call Steve Davis or Suzanne Silberman at MAG's Atlanta headquarters, 876-7535 or 800/282-0224 (toll-free in Georgia).

## The Weekend at a Glance

FRIDAY NOVEMBER 11		SATURDAY NOVEMBER 12		SUNDAY NOVEMBER 13
Morning	Afternoon	Morning	Afternoon	Morning
ALLERGY				
		CHEST DISEASE		
		NEUROLOGY		
		NEURO- SURGERY		NEURO- SURGERY
		OPHTHALMOLOGY		
OTOLARYNGOLOGY				
		PATHOLOGY		PATHOLOGY
		PLASTIC SURGERY		
PSYCHIATRY				



# Uncompensated Health Care in Georgia — An Emerging Public Policy Problem

Ann Marchetti

## Background

Making appropriate health care available to Georgians who aren't covered through either Medicaid, Medicare, or private health insurance programs is a problem that has become critical to all 159 Georgia counties, as it has to counties in other states. In Georgia, however, the issue is particularly acute because national data shows that health insurance coverage is linked to income, and this State ranks among the poorest in the nation. While statewide efforts to spur the economic development of depressed areas is currently underway, some 16.6 percent of the population had income below the Federal poverty line in 1979, and Georgia placed as the eighth poorest state in the nation that year in a ranking of states' population in poverty. In the most urban and rural counties of the state, the percentage of population in poverty is much higher. The problem of poverty, coupled with Federal cutbacks in health and social service programs and revenue sharing, has made it

---

**The trend in insurance coverage, along with the specter of growing medically indigent populations with special health care needs, such as people with AIDS, has resulted in the Association County Commissioners of Georgia giving the issue of uncompensated health care focused attention on both the state and national levels.**

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Ms. Marchetti is Policy Analyst for the Association County Commissioners of Georgia, 127 Peachtree St., Ste. 404, Atlanta, GA 30303. Send reprint requests to her.

especially difficult for many Georgia counties, as providers of last resort, to respond to the needs of their communities.

National studies have already documented the increase in the numbers and percentage of Americans who are uninsured or underinsured and therefore do not have access to health care. This trend is a strong one in Georgia, and has resulted in increased inpatient and outpatient admissions of people hospitals classify as indigent or charity patients — those with incomes of equal to or less than 200% of the federal poverty guideline with no public or private health coverage. In Georgia, counties are commonly understood to have some responsibility for their medically indigent, although the nature of this mandate has not been fully specified in law. So, the trend in insurance coverage, along with the specter of growing medically indigent populations with special health care needs, such as people with AIDS, has resulted in the Association County Commissioners of Georgia

giving the issue of uncompensated health care focused attention on both the state and national levels.

### **The Uninsured and Underinsured in Georgia**

Several surveys conducted by state agencies indicate that the percentage of Georgians who lack either public or private health insurance hovers somewhere around 16-18%, or 1 out of every 6 Georgians.<sup>1</sup> The researchers, however, caution that this figure may be an underestimate, since no attempt was made to determine whether these uninsured have children or other dependents who are relying on them for coverage; national data shows that the uninsured tend to be of child bearing age. An additional 18% of Georgians are underinsured. Their health coverage excludes or limits benefits for major medical conditions or services. About half of the state's population in poverty under the Federal guideline are enrolled in Medicaid, the primary public insurer of people in need. Those who are covered are unemployed because they are aged, blind, disabled, or women with dependent children.<sup>2</sup> Other Georgians in poverty but not covered by Medicaid include the unemployed who are considered able-bodied and those who work in low-paid jobs.

It is likely that the percentage of uninsured Georgians will stay on the rise. Major insurers within the state have already announced 30-35% rate increases on the premiums paid by employers for employee group health benefit plans.<sup>3</sup> These increases mean that it is improbable that more employers will provide benefits to employees; indeed, some employers may be dropping their plans. A 1987 survey of small employers (less than 100 employees) in the metro-Atlanta area, generally considered the most competitive in the state, found that one-third of these firms currently do not provide employee health insurance benefits; a supporting survey showed that insurers are reluctant

to underwrite plans for small or high-risk employers.<sup>4</sup> The employed uninsured also tend to be in jobs at the low end of the wage scale and/or employed in occupations, such as the service industry, agriculture, and some of the trades, that typically do not offer health insurance.<sup>5</sup> Statewide, many of Georgia's major employment sectors fall into these categories.

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### **A 1987 survey of small employers (less than 100 employees) in the metro-Atlanta area, generally considered the most competitive in the state, found that one-third of these firms currently do not provide employee health insurance benefits. . . .**

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Actions by employers who continue to provide insurance benefits to limit these costs may result in more Georgians who are underinsured, and will further limit cost-shifting by hospitals. (Cost-shifting — charging paying patients more in order to offset the costs of those who can't pay — has been the traditional mechanism for recovering uncompensated care by hospitals.) About 60 percent of employee benefit plans are now managed care systems. These include preferred provider arrangements or health maintenance organizations, and such plans increase at the rate of 5-10 percent each year.<sup>6</sup> The managed plans strive to reduce in-patient hospital procedures, limit payments for some services, or exclude certain medical conditions. In addition, more employers are shifting costs to employees by imposing

higher employee premiums, deductibles, and out-of-pocket copayments. The cost of the health care that is limited or excluded under managed care plans can often translate into uncompensated care costs for hospitals.

Because of these trends, the number of the uninsured and underinsured working poor in Georgia is high. Inclusion within an employer group health plan varies not only with size of the firm but also with the level of pay and type of occupation. Georgians who support households by working in full time jobs at minimum wage do not make enough to meet the federal poverty guideline and probably do not have health insurance. Some 39 percent of all Georgia households have income under \$10,000, just over the poverty line for a family of three; although statistics on the health insurance status of these are not available.<sup>7</sup> Purchasing health insurance on an individual basis is prohibitively expensive for this population. At the same time, the working uninsured and underinsured are not eligible for Medicaid, the public insurance program funded by the Federal government and the states.

### **The Structure and Costs of Indigent and Charity Health Care**

Except for a few federal health centers and county-sponsored clinics, there is no basic primary health care system for the medically indigent in Georgia. Primary health care includes all those services normally provided by a general practitioner physician; adequate primary care has been shown to reduce the need for more costly medical care in hospitals.<sup>8</sup> For most medically indigent Georgians, hospital emergency rooms are typically where health care is sought. Hospitals provide acute care to patients with condition(s) that are considered urgent.

Hospitals in Georgia have been affected by the same trends impacting the industry across the



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**While the uncompensated care crisis is certainly the most dramatic in Fulton County, the same crisis is being repeated in other counties, albeit on a smaller scale.**

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country. In the last decade, hospital occupancy rates have dropped to an average 55.3 percent,<sup>9</sup> and changes in Medicaid, Medicare, and the private insurance industry have reduced hospitals' ability to shift patient revenues to cover the cost of whatever uncompensated care has been provided. To stay in operation, hospital charges to patients must be high enough to offset the overhead cost of unused bed space, special medical equipment, and other losses. Then, additional charges must be factored in if a profit is to be made or new revenue generated. In Georgia, hospitals charge paying patients an average 35 percent more than the actual cost of service; in some hospitals charges are 55 percent more than costs.<sup>10</sup> Hospitals, therefore, are an expensive vehicle for providing health care.

In 1986, Georgia hospitals reported providing \$253.4 million (before reimbursement by any outside source) in care to people considered indigent and charity patients.<sup>11</sup> The care, however, is not disbursed evenly throughout the industry. There are two yardsticks by which to measure such uncompensated care. First is the sheer volume of uncompensated care provided. Viewed from this perspective, some 70 percent of the indigent and charity care given in 1986 was provided by just 10 hospitals located in eight urban counties. An alternative measure of uncompensated care

effort by hospitals is to contrast the cost of this care with hospitals' adjusted gross revenue. On average, in 1986, such uncompensated care amounted to 6.3 percent of Georgia hospitals' adjusted gross revenue. However, in that year, just under 50 of the 197 hospitals actually provided uncompensated care at a level equal to or greater than 4 percent of adjusted gross revenue, before applying any outside reimbursement. All of these were public hospitals except four non-profit, and four for-profit facilities. Less than half were required to provide a minimal level of uncompensated care under the Federal Hill-Burton Act.

**Uncompensated Care:  
Impact on Counties**

Except for a few state programs to offset uncompensated care given for specific medical conditions, there is no systematic method for financing the health care of the medically indigent on a statewide basis. Hospitals look to county governments to pay for uncompensated care.

In 1986, some 55 counties provided direct funding to hospitals for the care of medically indigent patients and related purposes. Such support totaled \$95.6 million and ranged from \$0.50-\$80.65 per capita in the respective counties. At the high end of this range is Fulton County (Atlanta). The county's contribution supported Grady Hospital, operated by the Fulton-DeKalb Hospital Authority. This hospital provides both the largest volume of indigent care and the highest proportion of indigent care, 45% of adjusted gross revenue. Uncompensated health care accounts for most of Fulton County's operating budget and is threatening the ability of the county to provide other basic community services. While the uncompensated care crisis is certainly the most dramatic in Fulton County, the same crisis is being repeated in other counties, albeit on a smaller scale.

The problem of paying for medically indigent patients who originate from outside county boundaries is of particular concern to county governments that fund hospitals for providing indigent and charity care. In some of these hospitals, the percentage of uncompensated care attributed to out-of-county indigent and charity inpatients alone ranges up to 92 percent. To respond, the Association County Commissioners last year adopted a resolution supporting the concept that a standard millage should be levied by each county and dedicated to uncompensated care. The Association also called on the state to establish a fund for indigent care and to convene a special study commission to develop a coordinated state response to the problem of medical indigency.

One of the reasons why so many indigent and charity patients originate from out-of-county is because hospitals in rural Georgia — both public and private — have special problems. Many are facing financial collapse because of decreased occupancy and patient revenue — rural hospitals have been particularly hard hit by the changes in public and private health insurance pertaining to hospital admission and reimbursement. Remote areas also have great difficulty in attracting medical professionals. Ten counties, eight of them rural, have hospitals that appear to be failing. That is, hospital charges to patients are far less than the hospitals' operating costs. Some county governments are supporting these hospitals each year, yet few of these facilities are able or willing to provide indigent/charity care.

For counties supporting a hospital that is performing an expensive level of uncompensated care of suffering from the financial problems common to rural hospitals across the nation, closing the facility or selling it to a for-profit concern is an attractive option. This is increasingly the case because of



shrinking local revenues and increasing state and federal unfunded mandates. Such closings or sales often creates pressures on the publicly funded hospitals of neighboring counties. Patients that would have been served by facilities that have closed are displaced into another county. Similarly, a hospital purchaser concerned with profit margins is likely to limit the amount of uncompensated care provided, also forcing these patients out-of-county.

### **Health Care Needs of Special Populations**

#### *AIDS*

In a ranking of states by prevalence of Acquired Immune Deficiency Syndrome (AIDS), Georgia places as eighth.<sup>12</sup> By next year, 2,145 Georgians with AIDS are anticipated; by 1995, the cumulative number of Georgians exhibiting AIDS symptoms will soar to 32,500. With the lifetime cost per case estimated at \$50,000-\$150,000 depending on the mode of treatment, it is clear that the cost of providing care to people with AIDS will be tremendous.

Many Georgians who have contracted AIDS are covered, for a time, under their employer's health insurance package. Typically, however, the physical stress of the disease forces its victim to leave his/her job, and health insurance benefits are exhausted soon after. While no figures are available for Georgia, it appears that some insurers are excluding or limiting AIDS coverage under group policies and denying applications for individual coverage to people who could be at risk for AIDS. Without private group or individual insurance coverage, people with AIDS must rely on their own resources or become qualified for Medicaid or Medicare. The state funds two clinics for people with AIDS in two urban counties.

A proposal to fund an Optional Medically Needy component under Medicaid, which would have included some people with AIDS,

failed to pass the 1988 session of the General Assembly. Currently, an indigent person with AIDS is placed on the Supplemental Security Income (SSI) program until his or her eligibility is fully determined. The SSI program provides both income maintenance and Medicaid benefits. However, because most people with AIDS have accumulated work credits under the Social Security system, they are ultimately placed on the Social Security Disability Insurance (SSDI) program which provides cash benefits but not Medicaid. The Optional Medically Needy component would have helped to fix this glitch.

Many of these individuals will qualify for Medicare, but the two-year wait to receive benefits generally means that the help arrives too late to be of any use. In 1987, Georgia hospitals reported providing \$6.6 million in care to AIDS patients. Of this amount, 4% was covered by Medicare; 23% was covered by Medicaid; 37% was paid by private insurance; 15% was self-paid, and 22% (\$1.45 million) was uncompensated.<sup>13</sup>

Over the course of the next 10 years, the public cost of providing health care and related support services to people with AIDS through Medicaid, Medicare, and medically indigent programs will challenge federal, state, and local governments. Counties alone do not have the financial resources to meet the need. Therefore, government at all levels must take action to ensure that both public and private health care resources and insurance programs are coordinated to provide appropriate, accessible care as cost-efficiently and effectively as possible.

#### *Maternal and Child Health*

Low infant birth weight (under 5 and ½ pounds) is the key factor associated with a need for neonatal intensive care and infant mortality or serious residual handicaps that later prevent normal functioning. Adequate prenatal care has been shown to be effective in increasing

birth weight and preventing the need for costly medical care for infants.<sup>14</sup> However, pregnant women and their children face special problems in obtaining health care, a fact reflected by Georgia's infant mortality rate of 12.5 per 1,000 babies in 1986. Fully 8% of all the live babies born in 1986 suffered from low infant birth weight.<sup>15</sup>

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### **Except for a few federal health centers and country-sponsored clinics, there is no basic primary health care system for the medically indigent in Georgia.**

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To respond to the need for maternal and infant care, the Georgia legislature elected in 1988 to cover under Medicaid all pregnant women and infants to age 3 whose income does not exceed 100% of poverty and increased the standard of need used to qualify for AFDC by 2.78%. For FY'89, state legislators reaffirmed a goal of 9 deaths per 1,000 births and expanded existing infant mortality programs by \$2.2 million state dollars (\$3.7 total with federal funds). This, in combination with related state programs for medically indigent pregnant women and infants means that virtually all pregnant women and infants in Georgia are covered by either an insurance or public health program.

In spite of this active effort at intervention, a lack of health care resources prevents many women and infants from obtaining care. Although obstetrician liability in Georgia has been reduced, insurance costs for these physicians have continued to limit the number of providers willing to perform obstetrical services — even for women covered by private insurance. Over one-half of Georgia's counties do



not have an obstetrician, and only 52% of the available doctors in the state will accept Medicaid patients, notwithstanding the State Department of Medical Assistance' generous provider reimbursement rate.<sup>15</sup> The state legislature is also attempting to establish midwifery programs and prenatal clinics, but professionals to staff these are also few and far between.

Some 70% of low birthweight infants require neonatal intensive care on an average of 21 days with a total bill or more than \$11,000 per child. However, for every \$1 in prenatal care expended, about \$2-\$11 in neonatal care is saved.<sup>15</sup> Some other conditions associated with low birth weight include cerebral palsy, mental retardation, blindness and deafness — about 5% of low birth weight babies will develop one or more of these problems. In addition to medical care, these handicaps also create other costly dependencies on public support.

The public cost and human tragedy that results from the lack of available prenatal care resources must be responded to by the federal, state, and local governments. Government leaders and the private sector must work together to find incentives to attract and retain obstetrical care providers, especially for underserved areas.

### *Teenage Pregnancies*

Georgia teens are reflecting national trends when it comes to pregnancy. In 1986, unwed teenagers in Georgia gave birth to 9,920 live babies; 10% of all live births in Georgia that year. Statewide, 26% of white unwed teenagers and 74% of black unwed teenagers gave birth in that year.<sup>16</sup>

In addition to the potential for giving birth to medically high risk infants because of inadequate prenatal care, teen mothers pose special challenges for our educational, social service, and public welfare systems. Teen mothers earn less over a lifetime than do other women,<sup>17</sup> and teen birth often heralds the beginning of dependency

on public support for several generations. While the Georgia legislature has increased funding for programs to prevent teen pregnancy, national as well as state leadership, with local government involvement, is needed to respond to this problem.

### *Aging Georgians*

From 1988 until 2000, the total state population of Georgia is expected to increase by more than 40% — but Georgians over 65 will increase at twice that rate, and those over 80 will increase by 140%.<sup>18</sup> While the concerns that have given rise to a national call for catastrophic and long-term care insurance affect all Georgians, they are of particular significance to our elder citizens.

The rising cost of health care means that a catastrophic illness could deplete the resources of any American, forcing these individuals and their families into poverty and dependency on public support. The impact of catastrophic illness on older Americans is particularly urgent, stripping seniors of a lifetime of savings. A national response to this problem is needed. Both the House and the Senate have passed HR 2470, the Medicare Catastrophic Illness Act. We commend the President for signing the bill. The legislation will cap out-of-pocket costs for Medicare-covered services for elderly and disabled persons who qualify for the program.

Long-term care is a special area of need for older Georgians. The availability of respite care and home care often means the difference between maintaining some independence in the home setting or requiring a nursing home facility. At the same time, a prolonged stay in a nursing home for those who need either skilled or non-skilled care takes a devastating financial toll on the elderly and their families. Coverage for nursing home care under Medicare is inadequate, and the Medicaid program requires beneficiaries to deplete their financial

assets before receiving benefits. For these reasons, Congress and the President should favor legislation that would help to finance long-term care.

### **Recommendations That Could Be Considered by the President-elect and the Congress to Respond to the Problem of Uncompensated Care**

The Association County Commissioners of Georgia finds that the issue of uncompensated health care costs is a priority concern of counties today. ACCG supports the concept that adequate basic health benefits should be available to the whole population, regardless of residence or socioeconomic differences, but finds that trends at the federal level and in the private sector affecting the availability of health care resources and insurance have resulted in serious financial impacts on counties who have acted as providers of last resort.

ACCG recognizes that the provision of health services to the uninsured and underinsured population is a shared local, state, federal government, and private sector responsibility, and that remedies must come from a joint effort by these sectors. However, ACCG believes that the federal government could be most effective by taking the lead role in addressing the issue of uncompensated care in a manner that is comprehensive and consistent nationwide. Therefore, ACCG respectfully submits the following recommendations for the consideration of the President-elect and the Congress:

- Reform the Medicaid and Medicare programs to better coordinate benefits with the needs of eligible populations with special medical needs, such as people with AIDS, pregnant women and young children, and aging Americans.
- Re-establish a federal commitment to health care planning, both to constrain the growth of health care costs and to ensure

the availability of appropriate and cost-effective health care resources. The role of local governments and the states in the planning process must be increased to ensure that implementation plans are responsive to local communities.

- Establish tax and other incentives for employers and the insurance industry that encourage the provision of employee health benefits for all workers. Policies used to do this should not have the effect of discouraging the development or expansion of private business, particularly in localities that depend on the private sector for economic development.

- Expand federal matching funds for Medicaid to allow state departments of medical assistance to establish insurance programs providing benefits comparable to employer group policies for purchase by people who are uninsured because they lack employer-sponsored policies and cannot afford or otherwise qualify for a private health insurance policy. Structure such insurance programs to permit premiums to be purchased by consumers on a sliding fee scale based on income. Legislation and regulations authorizing such insurance programs should contain mechanisms to discourage employers offering employee health insurance plans from discontinuing

these benefits in favor of the state insurance plan.

- Identify, in consultation with state and local elected officials, a minimum package of basic health services and resources that should be available to all Americans regardless of area of residence or ability to pay, and identify resources for providing these. Consider financing this package through a broad-based national tax system. The program should permit state and local governments to add additional services, financed by state or local funds; however, the program must provide for reimbursement to counties for the cost of care to people who do not have either public or private health insurance.

### Conclusion

The structure of our nation's health care resources and financing is increasingly at odds with the needs of Americans. As a result, counties in Georgia and elsewhere are being called on, to a greater extent than ever before, to fill in the gaps. Georgia counties want to help their citizens receive needed care. However, the scope of the problem of providing adequate health care to those who need it is beyond the capacity, administratively and financially, of counties alone. Therefore, the Association County Commissioners of Georgia calls on Congress and the President to implement strategies, in coordination

with the states, localities and the private sector, of making adequate health care accessible to and affordable by all Americans.

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## DALE L. TIPTON, M.D.

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**EDUCATION** University of California at Berkeley, A.B. Physiology; University of California School of Medicine, San Francisco, M.D. and Master of Science, Pharmacology.

**RESIDENCY** University of California School of Medicine, San Francisco: General Surgery — 2 years; Otolaryngology — 3 years.

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**OUTSTANDING ACHIEVEMENTS** Freshman Medical Student Research Award; Class President — 2nd year medical school; Student Body President — senior year medical school; Special Award by National Institute of Health to attend and present paper at International Congress of Otolaryngology in Tokyo, Japan; Chairman, Department of Otolaryngology, San Francisco General Hospital 1970-76; Chief of Medical Staff, Franklin Hospital 1982-84.



Dr. Tipton and residents examining post-operative patient in recovery room.

“I joined the Army Reserve shortly after completing my responsibilities as Chief of Staff of Franklin Hospital in San Francisco. I was intrigued with the idea of trying something different, such as Army Medicine.

“I find that the challenges and rewards of serving as an Army Reserve physician complement my civilian practice. For a number of years, I’ve been teaching as a member of the Clinical Faculty at the University of California School of Medicine, and I thoroughly enjoy the many teaching opportunities available to me in the Reserve. It is a rewarding experience to be involved in the training of Army medical students, interns, and residents. I also enjoy interacting and exchanging information with full-time Army physicians and seeing a wide variety of interesting clinical cases.

“After 18 years of private practice, I find it stimulating to be able to use my experience and expertise in a totally different medical setting. I highly recommend Army Medicine to any interested physician.”

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Axid is indicated for maintenance therapy for duodenal ulcer patients, at a reduced dosage of 150 mg h.s. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

**Contraindications:** Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H<sub>2</sub>-receptor antagonists.

**Precautions:** General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

**Laboratory Tests:** False-positive tests for urobilinogen with Multistix<sup>®</sup> may occur during therapy with nizatidine.

**Drug Interactions:** No interactions have been observed between Axid and theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement

compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Teratogenic Effects—Pregnancy Category C—**Oral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers:** Nizatidine is secreted and concentrated in the milk of lactating rats. Pups reared by treated lactating rats had depressed growth rates. Although no studies have been conducted in lactating women, nizatidine is assumed to be secreted in human milk, and caution should be exercised when nizatidine is administered to nursing mothers.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**Use in Elderly Patients:** Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported, it was not possible to

determine whether these were caused by nizatidine.

**Hepatic:** Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

**Cardiovascular:** In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

**Endocrine:** Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

**Hematologic:** Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H<sub>2</sub>-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs.

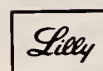
**Integumental:** Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients. Rash and exfoliative dermatitis were also reported.

**Other:** Hyperuricemia unassociated with gout or nephrolithiasis was reported.

**Overdose:** There is little clinical experience with overdosage of Axid in humans. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LD<sub>50</sub> values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

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# Uncompensated Medical Care: What's Being Done?

J. Rhodes Haverty, M.D.

**T**HE NATION AND OUR STATE have a serious problem in trying to deliver available, accessible, and acceptable health care to all people. It is estimated that 15% of the nation is without health insurance or any other health cost coverage at any given time. Generally speaking, middle and upper economic level working people are covered by personal insurance or by insurance provided by their employers as a fringe benefit. The poor, the elderly, and certain other groups are cared for by governmental programs, such as Medicare and Medicaid. This leaves approximately 35 million people in the United States who have no way to pay for needed health care.

## Working Toward Solutions

Dr. Ewe Reinhardt, a Princeton health economist, has written a considerable amount over the past few years on the subject of health care in America and the economics of that care. He notes three major goals that have been generally sought toward solving the health care problems in our society. These are (1) to distribute care equally on the basis of patients' needs rather than on their ability to pay, (2) to

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**The Georgia  
Physician Survey  
conducted in 1986  
showed that over 70%  
of Georgia physicians  
accepted Medicaid  
patients and over 80%  
accepted Medicare  
patients.**

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allow providers of health care the freedom to treat patients according to their best judgment and to price their services as they see fit, and (3) to have a system that facilitates cost control.

Dr. Reinhardt has stated that it is possible to attain only two of these three goals simultaneously. One may have egalitarian distribution of health care, with budgetary and cost

control, but at the expense of governmental intervention in the practice of medicine and its pricing. Also, one may have broad and equal distribution of health care and freedom from governmental interference, but with continually escalating costs. Or, one may have freedom from outside interference in the delivery of health care, with budgetary and cost control, but with care delivered only to those fortunate enough to be able to have those services paid for — a form of rationing. In America, we generally have preached the achievement of all three and practiced the second option. Recently, the third choice has become more evident, with the first waiting in the wings.

**P**rofessor Reinhardt's solution, greatly oversimplified, suggests that we need to accept what is already, in fact, in place: a tiered system of medical care. Those well-to-do citizens who can afford to purchase services *ad lib* might occupy one level. Those employees who have health care coverage as part of their salaries from work would be at another level of care. Those individuals covered by state or federal programs would find themselves at still another level of

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care, albeit an acceptable one. This level would have to be structured to include those individuals presently uncovered through lack of employment or through "falling through the cracks" of government programs because of not meeting certain criteria.

Prior to the explosion of knowledge and technology relating to health care, a two-tiered system really was in effect all the time. Roughly before the Second War War, patients could afford the costs of health care through private means or insurance, or physicians and hospitals treated them for free or at reduced charges which could be afforded. But with advances in technology and knowledge, and a tremendous population surge, along with a "great society" governmental philosophy, and a relative dearth of health care providers, the previous system became difficult to handle, and changes began to occur.

### **Looking Back**

The medical profession itself, however, must take its share of the blame for the predicament we find ourselves in at present. I can well remember the arguments used on the floor of the American Medical Association House of Delegates, and indeed also on the floor of the Medical Association of Georgia House of Delegates, with the introduction of governmentally proposed remedies that emerged in the 1960s. "If they [the government] are going to assume the responsibility for those people [the aged, the poor, or whomever], then they can assume the responsibility for paying my bill!" I can remember, too, the interminable arguments relating to what charges were usual, what were customary, and what was reasonable. And I also can remember wondering at the time what had happened to the unselfish and sacrificial giving that most of us had evidenced so generously in the not-too-distant past.

Groups of physicians for many decades have tried to solve the

problems of inadequate care to some because of inability to pay. Organized medicine, whether through local groups through county or state medical societies, through national specialty societies, or through the American Medical Association have come up with various suggestions for help. And all along, of course, the individual physician has tried to live up to the ethic of medicine. And yet physicians, too, are a part of our modern

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**Since 1984, almost half the states have introduced legislation intended to improve the medically indigents' access to health care or else have organized legislative or gubernatorial commissions to study health care financing.**

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affluent American society. Some physicians, too, have learned to love money and what it can bring. The lure of the good life is, indeed, a fierce and engaging master.

### **MAG's Efforts**

The Medical Association of Georgia has attempted from time to time to address the problems of those in need of medical care, whether or not that care can be afforded by those who need it. We have a long list of creditable efforts to help our financially strapped patients. One such effort resulted in the appointment of a Committee on Medical Care for the Disadvantaged in the summer of 1986. This committee was quite broadly based. It had rep-

resentation from practicing physicians throughout the state, medical school faculties, governmental agencies, consumer groups (including those affected by the problem), medical specialty societies, other state and national medical organizations, and legislative committees of the Georgia General Assembly.

This Committee deliberated diligently for the better part of a year. It defined and narrowed its interests to that population in the state which is uninsured or underinsured and uncovered by publicly funded programs. The committee and the MAG staff conducted several surveys and studied their results. A national survey indicated that approximately 70% of state medical societies had appointed special committees or had developed legislative proposals to address the subject. A somewhat similar study of the county medical societies within Georgia revealed that a few organized efforts to provide free or reduced-cost health care had been made and were ongoing, but the general conclusion was that most of the efforts were being assumed by individuals.

A review of the literature on the subject revealed that since 1984, almost half the states have introduced legislation intended to improve the medically indigents' access to health care or else have organized legislative or gubernatorial commissions to study health care financing. Georgia was among these, and in November, 1984, the Georgia Joint Hospital Care for the Indigent Study Committee published a report on the scope of the problem in our state, with some possible solutions suggested. So far, no significant implementation efforts have been made.

Spotty organized medical activity continues to take place. The Medical Societies of Kentucky and Wisconsin both have involved themselves in health care for the disadvantaged, both in conjunction with state appropriated monies. Other states are involved in one way



or another or indicate interest from time to time. Information continues to be shared by the AMA regarding the issue. One survey done about 4 years ago showed that over three-quarters of all physicians in the nation provided some free or reduced fee care. Additionally, the Georgia Physician Survey conducted in 1986 showed that over 70% of Georgia physicians accepted Medicaid patients and over 80% accepted Medicare patients. Physician groups and individuals continue to offer free medical care in their own communities.

**I**n April, 1987, the MAG Committee mentioned above made its report to the House of Delegates. The Committee had addressed solutions to the problem in three arenas: governmental initiatives, including legislative and gubernatorial; professional association initiatives, including efforts undertaken by organized medical groups; and individual practitioner activities and strategies, primarily including personal decisions made by physicians at the point of contact with the patient.

The House reacted generally favorably in accepting the recommendations made by the Committee. These recommendations included urging legislative and gubernatorial development of a state policy on medical care funding for the indigent; having the state medical association encourage its members and other employers to provide health insurance coverage for all employees and to urge insurance companies to facilitate this; and having MAG reaffirm its policy that no patient in Georgia be denied medical care for lack of funds and encourage its members to support that position. Though the House of Delegates watered down the original recommendations of the Committee a bit, nevertheless, the MAG clearly spoke to the issue, with suggestions for direction for change.

#### **Efforts of Other Players**

Private business has become more and more interested in issues

of employee health care and insurance coverage as their costs continue to spiral. The Atlanta Health Care Alliance, one of several business/health coalitions organized in the state, initiated two projects recently toward alleviating Atlanta's

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**It is estimated that  
15% of the nation is  
without health  
insurance or any other  
health cost coverage at  
any given time.**

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problem with the uninsured: a small-employer survey in the Atlanta area, and a low cost, private sector plan to cover employees of small businesses. They hope to act as a catalyst in helping address this enormous community problem. Clearly, the development of an insurance program for the millions of uninsured would require careful planning but would go a long way toward solving the problem.

The Georgia Hospital Association recently convened a committee of hospital administrators and staff, business leaders, legislators, and others to address the issues involved with uncompensated care. Representatives from the medical community present at that committee's meeting pointed out that hospital costs alone were not the only problem and that attention must be paid to many other costly aspects of health care. It is hoped that these deliberations will suggest solutions and not continue the often ineffective and fragmented efforts.

#### **Progress Report and Final Remarks**

Though the 1987 MAG House of Delegates directed that the approved recommendations of the

Committee on Medical Care for the Disadvantaged be carried out, little has been accomplished during this past year. The Governor chose not to appoint any special study committee. A Senate resolution did pass which will place on the November, 1988, ballot a constitutional amendment authorizing an Indigent Care Trust Fund. This Fund would be used to broaden Medicaid coverage and expand health care funding to rural and primary health care areas. It should be supported by the MAG. The Georgia Medicaid Program has increased its indigent medical care funding by a \$19 million increase of its FY 1989 budget to offer medical care to additional numbers of children and pregnant women. Discussions continue to abound, but not much else has happened.

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uninsured.**

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As Chairman of the Committee on Medical Care for the Disadvantaged, I am interested in and concerned about this issue, although it does not touch me as closely as it did when I was in the active private practice of pediatrics. Perhaps more forward motion in helping develop some positive answers to our problem could be achieved with a leadership more involved with the problem from day to day. And yet I have heard no outcry, no suggestions, nor have I been besieged with offers of help. Perhaps this issue is not as important to our society and to the Medical Association of Georgia as I think it is. If that's the case, I wonder why. . . . ■

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# The Cost of Compassion

## *Can Georgia Hospitals Afford It?*

Joseph A. Parker

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### **The hospital bill for uncompensated medical care has expanded to more than \$1 billion a year in Georgia.**

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**T**HE INDIVIDUAL PATIENT who cannot afford needed health care elicits the sympathy and concern of both hospital and physician, but the thousands of Georgians who today cannot pay for health care are threatening the very existence of many of our hospitals.

The hospital bill for uncompensated care has expanded to more than \$1 billion a year in Georgia, drawing health care into a spiraling dilemma: as the bill goes up, health insurance premiums rise out of the reach of more Georgians, and the increasing number of uninsured citizens pushes the cost of uncompensated care even higher.

In 1986, the breakdown of uncompensated care in Georgia looked like this:

Hospital charges not covered by Medicare or Medicaid .....	\$538,000,000
Bad debts .....	\$225,000,000
Charity and indigent care .....	\$213,000,000
Hill-Burton obligations .....	\$ 52,000,000
TOTAL .....	\$1,028,000,000

During that same period, hospitals' total patient charges came to \$4.168 billion. Thus, about one of every four dollars charged for patient care was never paid.

**A** close look at the single category of indigent care — or care for poor patients who do not qualify for government assistance — shows these facts:

- During the last half of 1986, Georgia's hospitals provided 157,700 days of inpatient care to more than 28,000 indigent patients. The medically indigent accounted further for more than 285,000 outpatient visits.

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Mr. Parker is President of the Georgia Hospital Association. Send reprint requests to him at North x Northwest Office Park, Atlanta GA 30339.

- During the last half of 1986, Georgia's hospitals paid \$97 million for indigent inpatient and outpatient care. That amount does not include losses incurred from Medicare and Medicaid shortfalls, bad debts, or the cost of charity care and Hill-Burton obligations.

Three factors are the heaviest contributors to uncompensated care; inadequate Medicare reimbursement, underfunding of Georgia's Medicaid system, and the growing number of Georgians who do not have health insurance.

#### **The First Cause: Inadequate Medicare Reimbursement**

The first factor, inadequate Medicare reimbursement, is the result of today's prospective payment system. When that system began in 1983, the government promised hospitals annual increases in Medicare payments that would keep pace with inflation. But the promise was an empty one; Medicare increases have fallen far short of the rate of inflation. This year, for example urban hospitals saw in-

## **A look beyond the statistics to the individual patients and the hospitals that care for them**

Uncompensated care goes past the dollar signs and figures to individual patients and the hospitals that care for them. Often those patients are caught between borderline poverty and inadequate government assistance, leaving the system to take its toll on both patient and hospital.

Here are some actual examples from Georgia's hospitals that show only too graphically how our current system is failing. Far from the exception, these examples illustrate a common problem in Georgia:

- A 52-year-old carpenter was treated for acute renal failure. He died, leaving a hospital bill of \$91,647.

- A 43-year-old man who earned \$134 a week was admitted to the hospital with acute appendicitis. His wife was unemployed and had terminal cancer. His unpaid bill came to \$10,539.

- A 47-year-old man severed his hand while working as a subcontractor. He did not have worker's compensation coverage but was covered under a group policy through his wife's employer. However, the insurer refused to pay because the injury was work-related. The wife's monthly income was \$750, and the couple had two small children. The family did not qualify for Medicaid. The unpaid bills came to \$56,000 for the hospital and \$15,000 for the physicians who treated the patient.

- A 5-year-old child fractured his femur while riding a bicycle. His father was self-employed and had no health insurance. The

unpaid hospital bill totaled \$8,679.

- A 62-year-old man was admitted to the hospital for evaluation of a lung mass. His Social Security retirement was \$179 a month, but he could not receive Medicare until he was 65. His wife worked at a fast food restaurant and did not have insurance. She was to retire within a month, and her Social Security retirement was set at \$216 a month. The patient was diagnosed with terminal lung cancer, but he was not eligible for State Aid to Cancer Patients because his condition was incurable. Further, because he owned two trucks — one for transportation and the other a 1953 non-operating Chevy truck — he was ineligible for Supplemental Security Income or Medicaid until he could sell the 1953 truck. He died within 2 weeks leaving a hospital bill of more than \$11,000.

- A 20-year-old unemployed man was admitted to the hospital with a gunshot wound in the head. His 77-day stay cost the hospital \$65,432. Medicaid paid \$534.

- A 51-year-old woman was admitted to the hospital for treatment of gangrene of the right foot resulting in amputation. She had worked as a cook in a restaurant, receiving just above minimum wage with no health insurance. Her husband received about \$550 a month from Social Security disability. She was not able to return to work, and her husband's income made her ineligible for Supplemental Security Income or Medicaid. Her outstanding hospital charges were \$14,000.



creases in the range of only .75% to 1.5%. And since 1983, overall DRG payments have gone up a mere 11%, while hospitals' costs have gone up 28%.

Last year, 43% of Georgia's rural hospitals and 33% of our urban hospitals lost money treating Medicare patients, and 75% of all our hospitals project a loss for this year. The Healthcare Financial Management Association estimates that next year the average Medicare inpatient will incur a hospital cost of \$4,961, while Medicare reimbursement for that patient will be no more than \$4,510.

### **The Second Cause: Georgia's Underfunded Medicaid Systems**

For fiscal year 1989, which began July 1, Medicaid funding saw a \$5.5 million cut. As a result, hospitals can now expect to receive Medicare reimbursement for only about 64% of their charges.

The breakdown of who pays what for Medicaid is also interesting. In fiscal year 1989, it will look like this:

The federal government	will pay .....	\$154,000,000
Georgia will pay .....	\$ 79,000,000	
Hospitals will pay ...	\$ 45,000,000	

Thus, our hospitals will pay more than half what the state contributes to the Medicaid system.

Medicaid also fails to cover a large number of Georgians who are poor but not poor enough to qualify for state assistance. Forty percent of Georgians who live below the federal poverty level aren't covered by Medicaid.

### **The Third Cause: The Growing Number of Uninsured Citizens**

The third causative factor of the uncompensated care problem is the large number of Georgians who are underinsured or who have no health insurance at all. Respectively, they make up 18.2% and 13.8% of the state population, and that adds up to about 1.8 million of our five mil-

lion citizens. Many are the "near poor" — persons who are employed but whose jobs don't offer health benefits and whose budgets can't support the cost of insurance premiums. Slightly more than three fourths of Georgia's uninsured citizens are part of households where at least one family member is employed.

The numbers of the uninsured continue to increase, to a large part because of the many small and midsize businesses that do not (and often cannot) offer health insurance benefits to their employees. Nationally, the uninsured population has grown 25% since 1980.

### **Rural Hospitals Hardest Hit**

All of those factors hit hardest at the rural level because, unlike many of their urban counterparts, our rural hospitals see a disproportionate number of patients who are elderly, who are very sick, and who seek medical care as a last resort.

More than half of Georgia's hospital are rural, and many of them are operating near the red because of uncompensated care. Some may even be forced to close if further public assistance isn't made available.

For the rural community, a hospital closure has far-reaching effects. It limits the public's access to health care and in turn hampers the economic growth of the community, because new industry is not attracted to locations that can't provide health care for its employees.

### **Nonsolution**

To survive the losses of uncompensated care, hospitals' only option is to shift the cost of caring for the poor to the patients who can afford to pay. Cost shifting forces hospitals to increase the bills of their paying patients by an average of 35%, and that add-on produces about a 1.5% profit on patient revenues.

But that's not a solution. While cost shifting does keep our hospitals in business, it enhances the problem of uncompensated care because it brings about higher insurance premiums. And higher premiums mean more Georgians who cannot afford health insurance.

Another nonsolution that has already received some attention in the Georgia legislature is a "sick tax," that, is a surcharge on paying patients. That proposal is one to be wary of, because it would extract an additional tax from patients who are already paying more than their share. Like cost shifting, a sick tax will only result in insurance rate increases.

Obviously, a problem as complicated as uncompensated care is not a candidate for a simple solution. But the overall answer is a broad-based payment system that places the burden on the shoulders of all Georgians and not on our hospitals and on the employers and individuals who pay for health insurance.

### **Feasible Solutions**

There are several feasible approaches, including

- An alcohol or tobacco tax.
- A higher income threshold for Medicaid eligibility.
- An expansion of the Medicaid program. Adding unemployed parents to the Medicaid role, for example, would make 22,000 more persons eligible for state assistance.
- Special state funding for hospitals that treat very large numbers of indigent patients.
- An increase in funding for existing state programs such as neonatal intensive care, cancer aid, and children's medical services.

The 1989 Georgia General Assembly will very likely address the issue of uncompensated care and may well advocate an expansion of Medicaid coverage. That alone won't solve the problem, but it is a good place to start. ■

# The Medically Uninsured: Who Cares?

Betty C. Castellani

**M**ARGARET JENSEN IS A HEALTHY 42-year-old single mother of three. She works for Clark & Company as a receptionist at a take-home salary of \$723 per month. She did not carry the group health insurance offered by her company because she could not afford the \$68 per month premium, which was almost 10% of her take-home pay. The "healthy" Mrs. Jensen has just been diagnosed with breast cancer and the disease appears to have metastasized to her lung.

Who cares?

Who cares that more than 35 million Americans are without health insurance?

Who cares that Medicaid coverage for the poor has dropped from 65% to 35%?

Who cares that nearly three-fourths of the uninsured employed workers have incomes of less than \$10,000 per year?

As a civilized society we have an ethical and moral responsibility to see to it that necessary health care is available to every individual regardless of his or her ability to pay. No caring person would argue that proposition. The dilemma with

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**The concept of socialized medicine proposed by many is not the answer because socialized medicine results in the abuse of our medical resources, not the prudent use of a limited, costly resource.**

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which we struggle is to determine the equitable way that is to be accomplished.

**T**he literature is filled with suggestions:

- A tiered system of medical care could be implemented where various levels of care could be bought based on one's ability to pay.

- A low-premium assigned risk pool could be designed where the "risks" are evenly proportioned so that every insurance company would get its fair share.

- Physicians and health care providers could participate in scaled charges based on a person's ability to pay.

- Government sponsored programs such as Medicaid and Medicare could be expanded so that no one in need is excluded.

Edward N. Brandt, Jr., M.D., Ph.D., and Chancellor of the University of Maryland, suggests that there are four options for dealing with the dilemma of health care for the uninsured: (1) a universal or national health insurance; (2) federal programs aimed at specific populations; (3) each state determining the medical needs of its population and designing methods of providing them, (4) some original plan such as the one used in Maryland where hospital rates are set by the state.<sup>1</sup>

The problem is not a lack of interest or research or exploration of the issue. Writing about it, talking about it, and commiserating about it will never do anything except fill more journals and occupy more library shelves. What is needed is someone with the vision to see that a critical problem exists and some-

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one with the courage to attack it tenaciously and someone with the endurance not to let go until some equitable solution is reached and in operation.

**T**he following observations need to be made about health care in this country today.

First, the present system of group health insurance which finances the largest portion of health care in this country is, in fact, a system which heavily taxes the lower income employee. If a company insurance plans costs \$75 per month for family coverage, the \$15,000 per year employee is paying a much higher rate based on percentage of income than the executive who makes \$85,000 per year. Both pay \$75. For the \$15,000 per year employee, that amounts to approximately 6% of his yearly income. For the \$85,000 a year employee, it is approximately 1%. Thus, when premiums go up to compensate for the higher costs of coverage (often generated to offset those individuals without coverage) the increase is more keenly felt by the lower income employees. Thus, the burden of caring for the uninsured is being carried by those least able to sustain it.

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**Not everyone can eat steak and live in a mansion. Perhaps equality of health care is as unreasonable as suggesting that everyone has the right to a life of splendor.**

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Second, doctors are often expected to provide free care for patients unable to pay. That they might object to doing this is perceived by the public as symptomatic of their uncontrolled greed.

Such a severe problem must be shared by society. We do not expect

farmers or food brokers to be solely responsible for the needs of the hungry. We would never suggest that architects or building suppliers solve the dilemma of homelessness. When they offer even token assistance the public is grateful.

Yet doctors have traditionally donated their services with little recognition or appreciation by the public in general. The American Bar Association and The American Medical Association jointly issued an editorial statement that contends one of the characteristics of a true professional relates to its special relationship to the poor. They maintain that the privilege to practice law or medicine carries with it the obligation to serve the poor without pay. Thus, all should give. "This is proper behavior of a learned professional. We believe 50 hours a year or roughly one week of time, is an appropriate minimum amount."<sup>2</sup>

While this is a worthy, desirable goal, the critical society fails to look at the unending economic, personal, and time demands that most physicians must endure. Few doctors have time to spare. To give time to the uninsured requires that it be taken from some place else.

Third, the poor and needy, the sick and afflicted have been with us since the beginning of time. They were a part of earliest recorded history and their presence is noted in the literature of all ages and cultures. They will never go away. The problem will never take care of itself. In fact, like a cancer that is constantly studied but never treated, it will only become more devastating with the passage of time.

**T**he concept of socialized medicine proposed by many is not the answer because socialized medicine results in the abuse of our medical resources, not the prudent use of a *limited, costly* resource. If there were no price to pay, doctors would be deluged with lonely, hurting people whose pain comes from the scars of living, not the ravages

of disease. Hospitals would be filled with those longing for "three hots and a cot" rather than those requiring skilled medical care and training. In this climate we would quickly encounter an enormous shortage of *competent* doctors and effective care.

The attitude of too many Americans is that "if I am not effected, I don't care." The truth is that every single person *is* effected, and it is in the best interests of every American to care considerably. Thus we might apply John Stuart Mill's ethical theory of utilitarianism.

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**Such a severe problem must be shared by society. We do not expect farmers or food brokers to be solely responsible for the needs of the hungry.**

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The greatest good for the greatest number would be a program where every person has available appropriate health care so that *real* needs are met. The costs of such care would be assigned so that no class or profession is unduly taxed or deprived. Not everyone can eat steak and live in a mansion. Perhaps equality of health care is as unreasonable as suggesting that everyone has the right to a life of splendor. But in the interest of a civilized society, everyone has the right to have food and shelter and to be cared for when he or she is critically ill or injured.

Since all of society is effected by this problem, but particularly health care professionals and the Margaret Jensens of the world, some action is critically needed. *She* is economically and politically powerless. Therefore, if change is to take place,



the burden is on the health care professionals who have the resources and the power to provoke changes to be implemented. Our present system of health care delivery is not fair or equitable, and it is not working for the medical profession or the Margaret Jensens among us.

Maybe doctors are too busy to invest their valuable time in this issue. But sometimes people have to sacrifice doing good things to do better things. If each person tries to solve the problem individually by seeing their fair share of charity patients, the result will only amount to a ripple in the water. Real change must be more far reaching and innovative if the problem is going to be resolved in some truly equitable manner.

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**If each person tries to solve the problem individually by seeing their fair share of charity patients, the result will only amount to a ripple in the water.**

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**H**aving said all that, I would like to add that the problem will not be solved in 1988, no matter how invigorated a group becomes. Yet the problem is with us this moment and must be addressed. There is an intangible satisfaction and sense of meaning that comes from

giving of ourselves. When we give something of ourselves, when we care without thought of reward, then we are on our way to leading lives that are very satisfying. Happiness is always a by-product of doing something worthwhile with our lives. It can never be sought or bought. One doctor only charges patients if they have insurance. If they don't, he doesn't get paid. My guess is that he would not want to give that practice up because, for him, it gives his life and his work enormous meaning.

Who cares? He cares.

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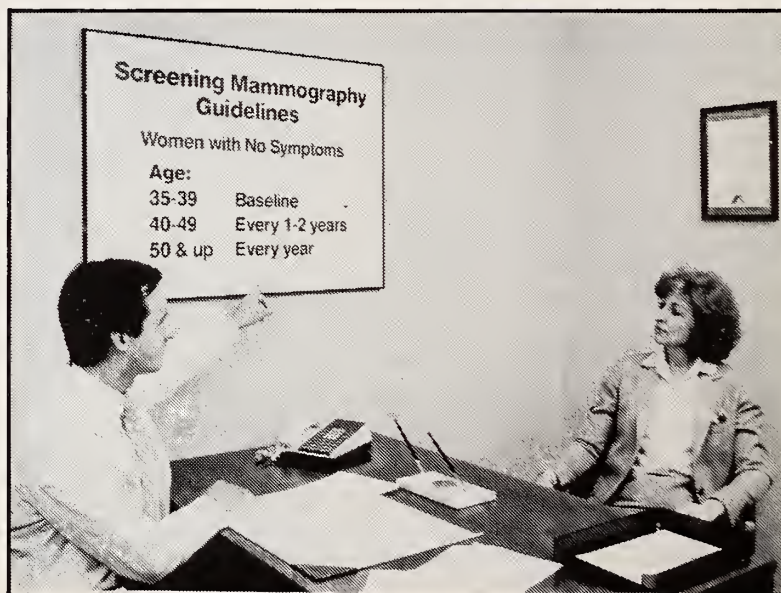
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# Incidence and Survival Rates for Cancer in Atlanta, 1975-1985

Raymond S. Greenberg, M.D., Ph.D., John F. C. Sung, Ph.D.,  
Jonathan M. Liff, Ph.D., and W. Scott Clark, M.S.

## Introduction

**I**N 1975, a population - based cancer registry was established in metropolitan Atlanta, Georgia, to monitor the patterns of cancer occurrence and prognosis. During the interim, two reports have been published on cancer incidence in this population.<sup>1,2</sup> The present analysis includes evaluations of stage at diagnosis and survival rates, as well as an update of information on incidence.

## Materials and Methods

The present data were collected by the Georgia Center for Cancer Statistics under contract from the National Cancer Institute. The operation of this registry has been

## Abstract

**S**URVEILLANCE OF ALL CANCERS diagnosed between 1975 and 1985 among residents of metropolitan Atlanta revealed a total of 52,805 malignancies. The age-adjusted incidence rates (per 100,000) by race and gender were: white males, 408.1; white females, 307.2; black males, 471.6; and black females, 261.9. Blacks had elevated incidence rates for malignancies of the uterine cervix and prostate, whereas whites had excesses of lymphomas and cancers of the urinary tract, uterine corpus, and ovaries. Among whites, 42% of neoplasms were localized, compared with only 32% among blacks. Cancers of the uterine corpus, prostate, and urinary tract were the most likely of all malignancies to be localized. The overall 5-year survival rate was 49%. Five-year survival rates by stage were: local, 75%; regional, 44%; distant, 18%. The highest survival rates were found for patients with cancers of the uterine corpus and breast, whereas malignancies of the respiratory system and non-bowel digestive organs had the worst prognoses.

described elsewhere,<sup>1,2</sup> so only a brief overview is provided here.

The Center has a staff of trained medical record abstractors who visited each hospital in and around five counties of metropolitan Atlanta (Clayton, Cobb, DeKalb, Fulton and Gwinnett counties). At each of these 37 hospitals, pathology reports and discharge diag-

noses were reviewed to identify all cancer patients, except those with non-melanotic skin cancer. A standard medical record abstract was completed for each eligible patient who resided within the five county catchment area. The abstract included items of demographic information, as well as topography, morphology, stage and

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**Table 1 — Number of new diagnoses of cancer among residents of metropolitan Atlanta, by anatomic site, race and sex, 1975-85**

Anatomic site	White				Black			
	Male		Female		Male		Female	
	n	(%)	n	(%)	n	(%)	n	(%)
Oropharynx	954	(4.9)	548	(2.6)	346	(5.8)	141	(2.6)
Colon	1,713	(8.8)	2,054	(9.6)	418	(7.0)	596	(11.1)
Rectum	693	(3.6)	679	(3.2)	167	(2.8)	194	(3.6)
Other digestive organs	1,474	(7.6)	1,254	(5.9)	810	(13.6)	507	(9.5)
Respiratory system	5,220	(26.8)	2,175	(10.2)	1,575	(26.4)	371	(6.9)
Breast (female)	—	—	6,437	(30.1)	—	—	1,480	(27.6)
Uterine corpus	—	—	1,540	(7.2)	—	—	300	(5.6)
Uterine cervix	—	—	691	(3.1)	—	—	498	(9.3)
Ovary	—	—	993	(4.6)	—	—	198	(3.7)
Prostate	3,201	(16.5)	—	—	1,477	(24.7)	—	—
Urinary tract	1,816	(9.3)	761	(3.6)	282	(4.7)	168	(3.1)
Hematopoietic system	832	(4.3)	757	(3.5)	227	(3.8)	238	(4.4)
Lymph nodes	682	(3.5)	638	(3.0)	135	(2.3)	99	(1.8)
Other	2,232	(11.5)	2,200	(10.3)	234	(3.8)	301	(5.6)
Unknown	638	(3.3)	654	(3.1)	282	(4.7)	264	(4.9)
All sites	19,455	(100)	21,381	(100)	5,953	(100)	5,355	(100)

the first course of treatment of the tumor. In addition to identifying cases at clinical facilities, the abstractors visited each of the 15 free-standing pathology laboratories in and around Atlanta. Computerized death certificates for the State of Georgia also were reviewed quarterly to identify persons with a cancer cause of death who had not been registered through either hospitals or laboratories. The present study was confined to patients diagnosed between January 1, 1975, and December 31, 1985.

An attempt was made to follow all patients through the end of calendar year 1986 to determine vital status and causes of death. The primary sources of information on vital status were hospital records, with supplementary data collected from the records of physicians and the quarterly review of computerized death certificates for the State of Georgia.

The study period was centered around the 1980 U. S. Census,<sup>3</sup> to allow the most accurate estimate of the size of the source population. Incidence rates and corresponding standard errors were calculated by gender and age and then summa-

rized by direct age adjustment<sup>4</sup> using the 1970 U.S. population as the standard. Survival analysis was performed with the Kaplan-Meier product limit estimator,<sup>5</sup> with death from any cancer as the outcome. Persons who died of other causes were considered to be censored at the times of death. A generalized Wilcoxon test<sup>6</sup> was used to assess the statistical significance of differences between pairs of survival curves.

### Results

During the 11-year period of study, a total of 52,805 cancers were registered among residents of metropolitan Atlanta. Of all reported malignancies, 40,836 (77.3%) occurred among whites, 11,308 (21.4%) among blacks and 661 (1.3%) among persons of other races. Overall, the most common site of cancer was the lower respiratory tract (n = 9,387, 17.8%). Neoplasia of the female breast was the next most common type of malignancy (n = 7,981, 15.1%), followed by cancers of the colon (n = 4,812, 9.1%) and prostate (n = 4,701, 8.9%).

For all types of cancer combined,

94.9% of cases were detected through inpatient hospital admissions. The remainder of registrations were obtained from outpatient facilities (1.8%), death certificates (1.1%), autopsies (0.6%), as well as offices of physicians, free-standing pathology laboratories and nursing homes (1.6%). Outpatient facilities contributed relatively large percentages of patients with cancers of the oropharynx (6.2%), the hematopoietic system (5.6%) and lymph nodes (3.6%). Screening at free-standing pathology laboratories was particularly helpful in the identification of patients with neoplasms of the oropharynx (3.1%). Cancers of unknown sites were detected from death certificates with comparatively high frequency (4.9%). Autopsies revealed 1.7% of prostate malignancies and 1.7% of malignancies of digestive organs other than the large intestine.

**W**hen all anatomical sites were combined, the percentages of histologically confirmed cases were 92.6% among whites and 89.5% among blacks. The highest frequency of histologic assessment

Table 2 — Average annual age-adjusted cancer incidence rates by race, sex, and site in metropolitan Atlanta, 1975-85.<sup>1</sup>

Anatomic Site	White		Black	
	Male	Female	Male	Female
Oropharynx	19.4	7.9	24.7	7.1
Colon	38.3	30.2	34.5	30.4
Rectum	14.8	9.8	13.3	10.0
Digestive organs (excluding large intestine)	31.4	18.0	63.4	26.3
Respiratory system	107.5	32.4	120.5	19.2
Breast (female)	—	92.9	—	70.3
Uterine corpus	—	23.0	—	15.2
Uterine cervix	—	9.1	—	22.7
Ovary	—	14.5	—	9.6
Prostate	77.8	—	132.4	—
Urinary tract	38.6	11.0	22.1	8.3
Hematopoietic system	17.3	11.1	16.6	11.7
Lymph nodes	12.4	9.0	7.9	4.5
Others	37.0	29.9	13.7	12.9
Unknown	13.7	9.2	22.6	13.5
All sites	408.1	307.2	471.6	261.9

1. All rates expressed per 100,000 persons.

was observed for malignancies of the uterine corpus (whites, 98.6%; blacks, 99.0%). For both races, cancers of unknown sites had the lowest percentages of histologic documentation (72.3% and 68.7% for whites and blacks, respectively). Cytologic evaluation was employed for relatively high percentages of cancers of the respiratory system (whites, 10.1%; blacks, 14.0%), unknown sites (whites, 7.4%; blacks, 11.2%), and the ovary among blacks (4.6%). Visual inspection without subsequent histologic or cytologic confirmation was used most often for malignancies of the digestive organs among both whites (4.4%) and blacks (3.8%). Radiographic methods were the basis for diagnosis of comparatively high percentages of cancers of digestive organs (whites, 6.1%; blacks, 5.3%), respiratory system (whites, 4.5%; blacks, 3.9%), and ovary among blacks (5.0%). Other evidence, such as signs and symptoms, rarely served as the sole basis for establishing the presence of a malignancy. The actual diagnostic method was unknown to the registry for relatively high percent-

ages of cancers of the hematopoietic system (whites, 4.9%; blacks, 3.9%), digestive organs (whites, 2.9%; blacks, 3.6%), and the respiratory system among blacks (2.8%).

The distribution of patients by race and sex is shown in Table 1. Respiratory malignancies accounted for more than one-fourth of all neoplasms among both black and white males. Although prostatic cancer was the next most frequent type among males of both races, the percentage for blacks (24.7%) was considerably greater than that for whites (16.5%). Cancers of other digestive organs (including the esophagus, stomach, small intestine, pancreas and liver) also accounted for a higher proportion of malignancies among black males (13.6%) than white males (7.6%). In contrast, urinary tract tumors and those classified as "other" were more common among white males than black males.

Breast cancer was the most frequent malignancy among females of both races. For white women, the

respiratory tract was the next most common cancer site (10.2%), followed by the colon (9.6%). Colonic neoplasia accounted for a slightly greater percentage of malignancies among black women (11.1%), as did cancers of other digestive organs (9.5%). The relative frequency of cancer of the uterine cervix was markedly greater for black women (9.3%) than for whites (3.1%).

The average annual age-specific incidence rates for all types of cancer are depicted by sex for whites and blacks in Figures 1 and 2, respectively. Above age 55 in whites and age 45 in blacks, the incidence of cancer among males greatly exceeded that of females. At all ages, the incidence rates for white females were higher than those for black females. Among males, blacks had consistently elevated incidence rates except for persons above age 80.

Age-adjusted incidence rates are presented by race, sex and anatomic site in Table 2. The highest overall incidence was observed for black males (471.6 per 100,000



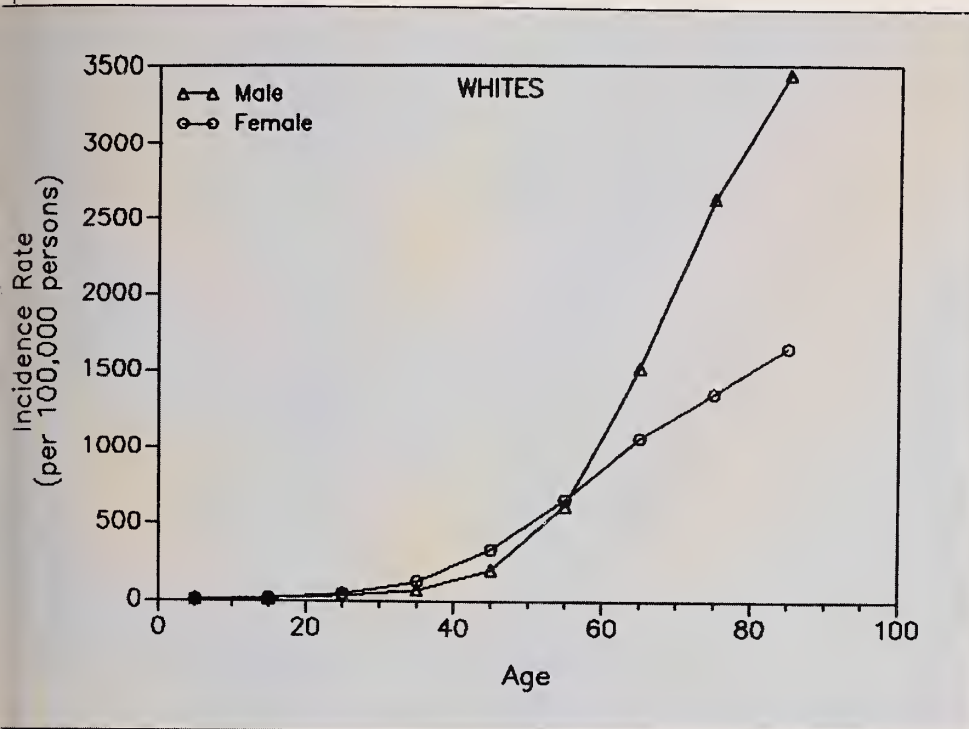


Figure 1. Average annual age-specific incidence rates of invasive cancer among whites, by sex in metropolitan Atlanta, 1975-1985.

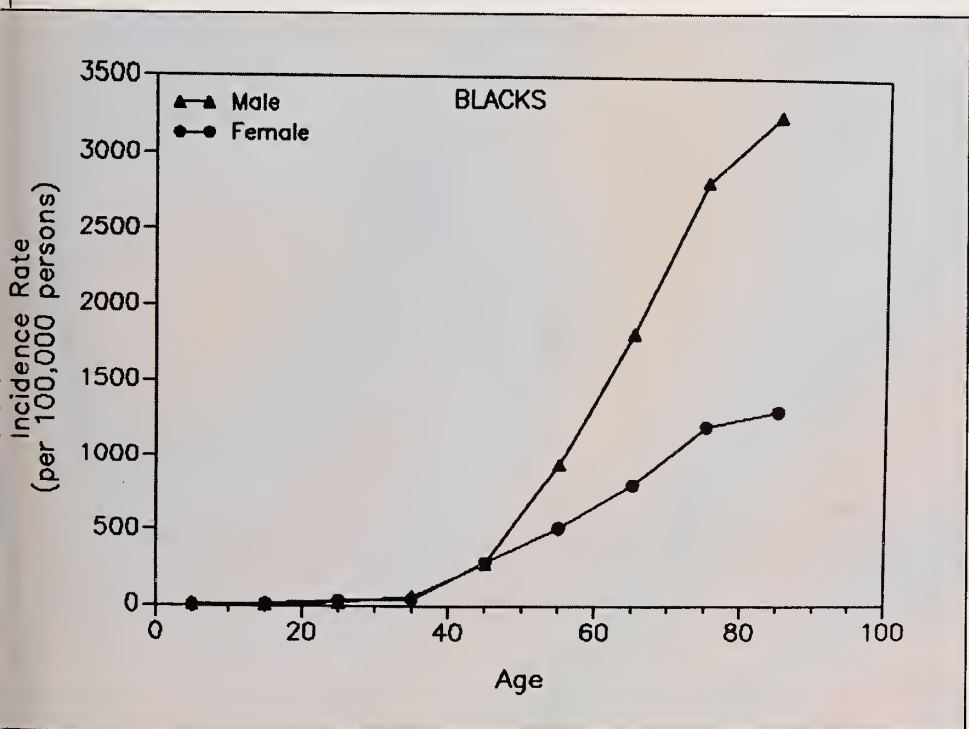


Figure 2. Average annual age-specific incidence rates of invasive cancer among blacks, by sex in metropolitan Atlanta, 1975-1985.

men), which exceeded the rate for white males by 15.6%. Among females, the reverse pattern was observed, with the incidence for whites 17.3% greater than that for blacks. The overall male-to-female ratio of rates was larger for blacks (1.80) than for whites (1.33).

Elevated age-adjusted incidence rates for blacks were observed for cancers of the uterine cervix (black-to-white rate ratio = 2.49), prostate (rate ratio = 1.70), digestive organs other than the large intestine (males: rate ratio = 2.02; females: rate ratio = 1.46), and unknown sites (males: rate ratio = 1.65; females: rate ratio = 1.47). In contrast, whites had higher incidence rates for malignancies of the urinary tract, uterine corpus, ovary, female breast, lymph nodes, and other sites (including cutaneous melanoma).

The stage distribution of cancers are shown by topography for white and black patients in Tables 3a and 3b, respectively. A summary stage could be assigned for 90% of white patients and 87% of black patients. Within each race, the percentage of unstaged cases was especially high for cancers with unknown sites of origin (whites, 84%; blacks, 77%). For all sites combined, whites had a larger proportion of localized malignancies (42%) than blacks (32%). The anatomic sites with the greatest tendencies toward localized malignancies within each race included the uterine corpus, prostate, urinary tract and "other" locations. For each of these sites, however, whites had a higher percentage of localized neoplasms than blacks.

The cancers with the highest frequencies of metastases were malignancies of the lymph nodes, ovaries, digestive organs and respiratory system. The racial differential in the percentages of remote site involvement among patients with these cancers was minimal. Nevertheless, blacks tended to have higher percentages of metastatic disease for all other sites.

Table 3a — Percentage distribution<sup>1</sup> of cancers by stage and anatomic site among whites in metropolitan Atlanta, 1975-85

Anatomic site	n	Stage			
		Local	Regional	Distant	Unstaged
Oropharynx	1,502	45	39	7	9
Colon	3,767	30	45	21	4
Rectum	1,372	37	37	16	10
Digestive organs (excluding large intestine)	2,728	20	27	39	14
Respiratory system	7,395	26	27	35	12
Breast (female)	6,437	56	34	6	4
Uterine corpus	1,540	78	9	7	6
Uterine cervix	691	58	26	7	10
Ovary	993	26	8	63	3
Prostate	3,201	66	9	17	8
Urinary tract	2,577	68	16	10	6
Hematopoietic system <sup>2</sup>	1,589	0	0	100	0
Lymph nodes	1,320	2	8	88	2
Others	4,432	73	14	7	6
Unknown	1,292	0	8	8	84
All sites	40,836	42	24	24	10

1. Percentage of cases within a designated anatomic site.

2. All hematopoietic system tumors are classified as "systemic."

Table 3b — Percentage distribution<sup>1</sup> of cancers by stage and anatomic site among blacks in metropolitan Atlanta, 1975-85

Anatomic site	n	Stage			
		Local	Regional	Distant	Unstaged
Oropharynx	487	23	54	18	5
Colon	1,014	22	44	27	7
Rectum	361	28	35	23	14
Digestive organs (excluding large intestine)	1,317	21	26	36	16
Respiratory system	1,946	21	26	38	15
Breast (female)	1,480	41	40	13	6
Uterine corpus	300	57	16	17	10
Uterine cervix	498	44	34	8	14
Ovary	198	24	6	63	7
Prostate	1,477	58	6	27	9
Urinary tract	450	55	22	16	7
Hematopoietic system <sup>2</sup>	465	0	0	100	0
Lymph nodes	234	3	5	91	1
Others	535	63	17	11	9
Unknown	546	0	8	15	77
All sites	11,308	32	25	30	13

1. Percentage of cases within a designated anatomic site.

2. All hematopoietic system tumors are classified as "systemic."

The observed 5-year survival rates are presented by anatomic site and stage in Table 4. About half of all patients survived at least 5 years from the time of diagnosis. The anatomic sites with the most favorable prognoses were uterine corpus, breast, uterine cervix, prostate, urinary tract, and "others" (including

melanomas and thyroid cancers). The lowest 5-year survival rates were found for cancers of unknown sites, digestive organs (including the esophagus and pancreas), and the respiratory system.

Prognosis also was influenced strongly by stage. For patients with localized malignancies, the 5-year

survival rates exceeded 70% for all sites except digestive organs (25%) and the respiratory system (48%). Among patients with metastatic disease, the most favorable outcomes were found for patients with malignancies of the lymph nodes, or "other" sites. Within each anatomic site, patients with unstaged disease



Table 4 — Overall five-year survival rates by anatomic site and stage of cancer in metropolitan Atlanta, 1975-85

Site	All Stages	Local	Regional	Distant	Unstaged
Oropharynx	50	71	36	23	45
Colon	52	86	56	6	31
Rectum	50	77	48	6	40
Digestive organs (excluding large intestine)	12	25	15	4	6
Respiratory system	19	48	17	2	10
Breast (female)	71	87	63	16	41
Uterine corpus	80	89	60	25	66
Uterine cervix	65	86	44	5	49
Ovary	43	86	58	23	25
Prostate	64	78	58	25	57
Urinary tract	62	77	41	10	47
Hematopoietic system <sup>1</sup>	34	— <sup>2</sup>	—	34	—
Lymph nodes	56	93	72	54	—
Others	72	77	66	37	59
Unknown	9	—	12	7	10
All sites	49	75	44	18	26

1. All hematopoietic system tumors are classified as "systemic."

2. Dashes indicate categories in which there were no registered patients.

had survival rates that were similar to those for patients with nonlocalized disease.

## Discussion

This report includes the most current information available on the incidence and prognosis of cancer in metropolitan Atlanta. A comparison of the race and sex-specific incidence rates in Atlanta with the corresponding rates for the entire United States<sup>7</sup> reveals general consistency. In several specific instances, however, the rates in Atlanta differ from the national experience. For example, the age-adjusted incidence of respiratory cancer among white males in Atlanta is 33% higher than the corresponding rate for the United States. A 15% excess of respiratory malignancies also was found for white females in Atlanta. In contrast, the incidence of respiratory cancer among black females in Atlanta was 37% lower than the national rate.<sup>7</sup> These differences probably are attributable to regional differences in the prevalence of cigarette smoking, as has been documented in local<sup>8</sup> and national<sup>9</sup> surveys.

In all demographic subgroups, the local incidence of colonic cancer was lower than observed for the entire country.<sup>7</sup> The deficit of colonic malignancies was particularly evident among blacks (males, 29%; females, 16%). In all groups except black females, rectal neoplasms also had lower rates of occurrence in Atlanta than elsewhere in the United States. Since diet may influence the risk of large intestinal neoplasia,<sup>10</sup> it is possible that the low incidence rates in Atlanta are attributable to protective patterns of food consumption.

The data from Atlanta confirm previously reported racial disparities in the incidence of specific cancers.<sup>11</sup> For instance, carcinoma of the uterine cervix was more than twice as common among blacks than whites. Similarly, the incidence of prostate cancer was 70% higher among blacks than whites. The reasons for the excesses of cervical and prostatic malignancies among blacks are uncertain, but it has been suggested<sup>12,13</sup> that racial differences in sexual practices or the occurrence of sexually transmitted diseases may be partially responsible. The National Cancer In-

stitute has undertaken a study in Atlanta and two other geographic areas to evaluate possible reasons for the excess incidence of prostate cancer and other malignancies (multiple myeloma, esophageal and pancreatic cancer) among blacks.

The stage distributions of cancers in Atlanta generally were similar to the national experience.<sup>14</sup> In a few particular instances, however, stage disparities were observed. For example, white women in Atlanta had a greater tendency for localized carcinomas of the breast (Atlanta, 56%; United States, 48%) and uterine cervix (Atlanta, 58%; United States 45%). Black women in Atlanta, in contrast, did not have stage distributions for these cancers that differed from those of blacks elsewhere. Thus, any evidence of early detection of breast and cervical malignancies in Atlanta was confined to whites.

Race-specific comparisons also indicated that white Atlantans had stage distributions for cancers of the large intestine that paralleled the national experience, but black Atlantans had relative deficits of localized neoplasia of the colon (Atlanta, 22%; United States, 29%) and rectum (Atlanta, 28%; United States, 35%). These findings suggest the

need to target new initiatives for early detection of large intestinal malignancies within the local black community.

**I**n Atlanta, blacks tended to have more advanced cancers than whites. The excesses of nonlocalized disease among blacks were greatest for cancers of the oropharynx, breast, urinary tract, uterine corpus and cervix. These ethnic differentials in stage distribution have been observed in national data<sup>14</sup> and probably reflect racial inequalities in access to medical care.

The survival results in Atlanta were comparable to those reported by the National Cancer Institute<sup>14</sup> and clearly demonstrated the prognostic advantage for patients with localized disease. Spread of neoplasms from the site of origin to regional organs or lymph nodes had especially detrimental effects for cancers of the oropharynx, uterine cervix and urinary tract. Dissemination from regional involvement to metastatic disease had particularly adverse prognostic influences for cancers of the large intestine, female breast and uterus.

Prognosis also was strongly related to the anatomic site of origin, with relatively high survival rates within stage for persons with lymphomas or cancers of the uterine corpus, breast, or prostate. Especially poor survival was observed for persons with respiratory or non-bowel digestive cancers. Overall, the low death rates for malignancies of the uterine corpus, prostate, urinary tract and "other sites" were attributable in part to the high percentages of localized cancers at these sites.

The present survival analyses were not stratified further by race because of small numbers of black patients within many specific categories of site and stage. Nevertheless, it has demonstrated elsewhere<sup>14-16</sup> that blacks tend to have lower survival rates for certain cancers, even after adjustment for racial differences in stage. The progn-

nostic disadvantage for blacks was evident particularly for neoplasia of the oropharynx, breast, uterine corpus and urinary tract.<sup>14</sup> To further evaluate racial differences in survival from the latter three cancers, as well as colonic malignancies, the National Cancer Institute has initiated a study in three geographic regions, including Atlanta. The possible prognostic factors under investigation include delay in seeking or receiving medical care, stage, thoroughness of diagnostic evaluation, type(s) of treatment prescribed, level of compliance with the therapeutic regimen, financial resources, other past or concurrent illnesses, nutritional status and social support. It is anticipated that this study will provide greater insight into the medical and social determinants of racial differences in survival from cancer.

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### **This report includes the most current information available on the incidence and prognosis of cancer in metropolitan Atlanta.**

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#### **Conclusion**

The primary goal of cancer registration is to document the patterns of cancer incidence and prognosis in a geographically defined population. The predominantly biracial, urban community of Atlanta provides an appropriate setting for the comparison of cancer occurrence among blacks and whites. The present data clearly demonstrate that blacks tend to have relatively advanced malignancies at diagnosis, especially for those involving the oropharynx, breast, uterine corpus, or urinary tract. These findings underscore the need for public education and screening programs directed at the black population.

#### **Acknowledgements**

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**The data from  
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## *The Changing Role of the Oncology Nurse*

*Carol B. Hughes, R.N., M.S.N., O.C.N., Linda Scheivelhud, R.N., O.C.N.*

**‘Until recently, the opportunities for nurses to deliver cancer care have been limited to the hospital. This article discusses the various ways this is changing.’**

**T**HE ROLE OF THE ONCOLOGY NURSE has evolved over the last several decades. Prior to the 1960s, there was not a medical or nursing specialty devoted to cancer. Radiation therapy was practiced by physicians primarily trained in diagnostic radiology. Surgical training was considered adequate for the delivery of cancer care.

### **In the Beginning**

It is difficult to identify any single event that initiated the remarkable growth that has been seen in the specialty of oncology. One factor was the establishment of a Committee on Cancer by the American College of Surgeons. This committee was instrumental in the development of national trends toward accreditation of hospital cancer programs, tumor boards, cancer registries, and formal training programs in oncology.

An early voice for cancer nursing at the national, state, and local levels was provided by the American Cancer Society (ACS). A national nursing advisory committee was established and was composed primarily of nurses who cared for patients at the few cancer institutions in existence.

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As late as 1948, work study programs for student nurses in collaboration with major cancer institutions were supported by ACS. Educational opportunities for nursing were provided by nursing sub-committees at the state and local units of the ACS.

**I**n 1964, the American Society of Clinical Oncologists was formed. The first certifying exam for medical oncologists was given in 1972. In the following year, a group of 20 oncology nurses working in cancer research facilities began discussions that led to the founding of the Oncology Nursing Society (ONS) in 1975. The membership in ONS today exceeds 13,000. ONS has given national stature to the collective voices of cancer nurses and provided a forum for the development of standards of cancer nursing practice. A bimonthly professional journal, the *Oncology Nursing Forum*, is published by the Society. In 1986, the first certification exam was offered to oncology nurses; 3,639 nurses are now certified.

Initially, the oncology nurse's role was in the clinical trials of new chemotherapy agents. This role was as a data collector. Under the supervision of the clinical investigator, the house staff was directly responsible for counseling the patient, observing for drug toxicity, and for drug administration. The house staff physician rotated from the



oncology service after a brief period; the nurses were assigned permanently. The study protocols were too complex for mastery in the short period of time available during the rotation. The clinical investigators learned that the nurse was an excellent source of information regarding patient status, and the nurse helped to provide continuity of care.

In time, the practice of medical oncology moved from large research medical centers to community hospitals. Consequently, the physicians took with them the expanded role of the oncology nurse. With physician support, nursing service departments began to establish positions for this emerging specialty. In time, oncology units opened, increasing the need for nurses interested in the care of cancer patients. It has been apparent that as the physician involvement in new and different treatment modalities increased, more opportunities have been created for the oncology nurse.

## Emerging Roles

### *Patient Education*

Within the field of oncology nursing, patient education has become a recognizable component. Patient education efforts have been prompted by patient rights issues, the consumer movement and informed consent. Nurses are

dealing with sophisticated patients knowledgeable about their chemotherapy protocol, their lab values, and their surgery. It is clear that teaching individuals about various aspects of their condition is an effective method for improving the quality of care. Numerous patient educational programs have been developed by nurses to supplement teaching efforts.

The alternatives and options for patients and their families have become complex. Today, women with breast cancer have a number of options available to choose from for the primary treatment of their disease. This can be confusing to breast cancer patients and is complicated further by the different opinions of physicians and reports in the media. The nurse is in a pivotal position to facilitate the decision-making process. This may involve expanding on information provided, redirecting questions, identifying resources, clarifying misconceptions, and/or validating feelings. All of these actions promote informed decisions and ultimate patient satisfaction.

### *Chemotherapy*

Prior to 1960, nurses were seldom involved in chemotherapy administration. Those patients who received chemotherapy were likely to have it administered by their physician. As chemotherapy became a common treatment

modality, nurses assumed a greater role in the actual drug delivery. Today, nurses not only teach other nurses the specialized techniques of administration but also are responsible for developing formal guidelines and standards to ensure safe chemotherapy administration.

### *Psychosocial/Socioeconomic*

Because of the nature of the disease, a special trusting relationship usually develops between the patient and the nursing staff. The patients have many fears of mutilation, pain, alteration in body image, loss of independence, and death. The nurse who knows and understands the principles of oncology and is aware of its clinical implications can convey an air of confidence that will offer emotional support and reassurance to the patient and family. The nurse sees the continuing psychological, social, and economic impact of cancer on the patient, the family, and others.

### *Symptom Management*

Frequently, the medical treatment for cancer can produce distressing symptoms and even life-threatening situations. Although progress has been made, the patient does not escape without some complications. These situations present a special challenge to

both the nurse and the oncologist. It is the nurse who is in a key position to observe and assess the intensity of these symptoms, plan appropriate nursing interventions, and notify the physician of pertinent observations.

## **Innovative Roles**

### *Screening and Early Detection*

Oncology nurses currently practice in a variety of subspecialties of cancer care. A responsibility common to all nurses is educating others about the risk factors, prevention, and early detection of cancer. It is evident that nursing is promoting these efforts of cancer control on both an organizational and individual basis.

The American Cancer Society's involvement in cancer detection and prevention efforts are well known. Many oncology nurses are involved in professional and public programs to facilitate these efforts.

The Oncology Nursing Society is committed to cancer prevention and early detection. Cancer prevention and early detection are integral parts of the published ONS outcome standards for both cancer nursing practice and public education. Also, 15% of the questions on the Oncology Nursing Certification Exam address cancer control.

Oncology nurses are participating in cancer prevention and detection activities in a variety of ways. Formal participation in these activities by Oncology Clinical Nurse Specialists and Oncology Nurse Coordinators is becoming part of their job expectation. These nurses offer programs for employees and the public on a regular basis. Increasingly, nurses are receiving specialized training in screening techniques, such as

oral exams, pelvic exams, and breast exams, and apply these skills as a direct service to the public. The nurses' ability to perform these procedures expand the availability of cancer screening.

Individualized teaching while the patient is hospitalized or in the outpatient clinic is accomplished using literature, teaching models, and demonstration/return demonstration. Cancer control programs developed by nurses are being used for closed circuit TV or VCRs and patients can view them at their convenience.

### *Biotherapy*

As the treatments for various cancers increase in diversity, the role of the oncology nurse expands. This is reflected in the development of the new cancer treatment modality — Biotherapy. Biotherapy is a term that encompasses the use of agents or approaches (Biological Response Modifiers) that modify the relationship between tumor and host by augmenting the host's immune system response to the tumor cells with resultant therapeutic effects.

Oncology nurses have played a crucial role in the development of biotherapy. The contributions have included conducting clinical trials by administering Biological Response Modifiers and monitoring, documenting, and evaluating their effects. Nursing interventions are focused on preventing and managing side effects while educating and supporting these patients and their families.

### *Research*

With agency support, nurses are becoming more involved in research. This involvement

includes participation in the research process with activities such as literature search, protocol development, and data collection. Increasingly, nurses are the principal investigators. Areas that are being researched by nurses include: patient and health education, symptom management, coping and stress management, pain control and management, and patient and family support systems.

### *Home Care*

For economic and humanitarian reasons, components of cancer care are moving into the home setting. This has prompted the growth and development of home health agencies, thus creating a new role for nurses. The nurse in this setting functions as a coordinator of services, deliverer of skilled care, teacher of patients and families, counselor and supporter, and facilitator for the utilization of community resources.

### *Conclusion*

Cancer nursing enables the nurse to give comprehensive care to patients with complex physical and emotional needs, to interact with patients/families, often in crisis situations; to plan nursing interventions using alternative approaches to meet the situations. These nurses are in a position to collaborate with other health professionals to provide a total team effort.

Until recently, the opportunities for nurses to deliver cancer care have been limited to the hospital. This is changing. Today the oncology nurse may be working in a home health agency, a hospice, a medical or radiation therapy private practice, or an ambulatory care setting with direct patient care responsibilities. ■



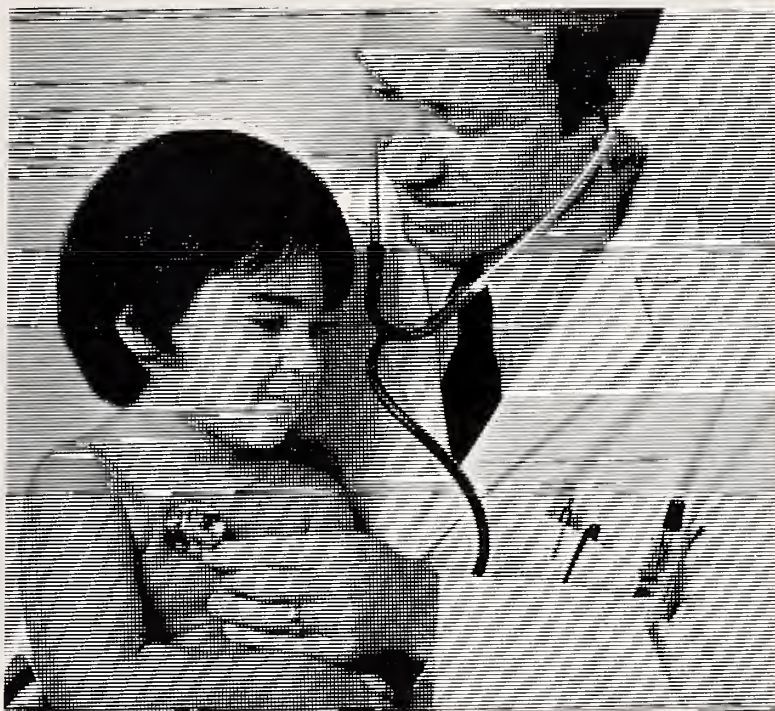
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## Peer Review Immunity for Bad Faith Activities

Patrick v. Burget Fails to Provide an Answer

Timothy J. Trankina

**‘The (Supreme) Court’s rationale in finding no active state supervision broke new ground in state action analysis. . . . The Patrick case indicates that future courts will look more closely at the actual state legislation involved. . . .’**

**T**HE UNITED STATES Supreme Court recently decided, in the highly publicized case of *Patrick v. Burget*,<sup>1</sup> to affirm a lower court ruling awarding Timothy Patrick, an Astoria, Oregon, physician, \$2.2 million in treble damages and attorneys’ fees against certain other Oregon physicians for their activities on a hospital peer review committee. The Court held that the “state action” doctrine does not protect Oregon physicians from federal antitrust liability for their peer review activities. Accordingly, the court did not reach the more visible issue in the case — whether the “state action” doctrine, if otherwise applicable, would protect the defendant physicians from actions taken in bad faith.

### Background

In 1972, Dr. Patrick, a general and vascular surgeon, became an employee of the Astoria Clinic (“Clinic”), a private group medical practice, and a member of the medical staff of Astoria’s only hospital, Columbia Memorial Hospital (the “Hospital”). After the expiration of his initial one-year contract, Dr. Patrick was invited to join the Clinic as a partner. Rather than accept the

offer, Dr. Patrick chose to start his own practice providing surgical services to the Hospital in competition with the Clinic. Throughout the ensuing 8 years, Dr. Patrick’s practice faced continual ostracism; Clinic physicians declined to give referrals and consultations and Clinic surgeons refused to provide back-up coverage for his patients. Contemporaneous with these activities, Dr. Patrick was frequently criticized for having inadequate back-up coverage and failing to obtain outside consultations. By 1981, several complaints about Dr. Patrick’s patient care had been reported by Clinic physicians to the Hospital’s medical staff Executive Committee. At the request of a Clinic partner, the Executive Committee began a review of Dr. Patrick’s Hospital privileges. The committee recommended terminating Dr. Patrick’s privileges, claiming his patient care was below Hospital standards. Dr. Patrick demanded the Hospital grant him a hearing to review the committee’s recommendation. An ad hoc committee, chaired by a Clinic partner, was called to hear the charges against Dr. Patrick, but, before the committee reached a final decision, he submitted his resignation to avoid the risk of termination.

Prior to the hearing, Dr. Patrick filed a lawsuit in the U.S. District

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Court for the District of Oregon, contending that "the clinic had initiated and participated in the hospital peer review proceedings to reduce competition from [Dr. Patrick] rather than to improve patient care."<sup>2</sup> At the trial, a jury found for Dr. Patrick and awarded him \$2.2 million in treble damages and attorney's fee. On appeal, the Ninth Circuit Court of Appeals reversed. The Court of Appeals concluded, notwithstanding its finding substantial evidence that Clinic doctors had acted in bad faith in the peer review process (the Court of Appeals characterized the doctors' conduct as "shabby, unprincipled and unprofessional"),<sup>3</sup> that even if the peer review process was used to disadvantage a competitor rather than to improve patient care, the doctors' activities and conduct were nonetheless immune from antitrust liability under the "state action" doctrine. This doctrine holds that certain actions taken by private persons, even if anticompetitive, are shielded from the antitrust laws. However, private persons can claim "state action" immunity from antitrust liability only when their anticompetitive acts are truly the product of state regulation.<sup>4</sup>

#### **The "State Action" Doctrine**

The Supreme Court has established a two-pronged test to

determine when anticompetitive conduct engaged in by private parties should be deemed "state action" and thus shielded from the antitrust laws.<sup>5</sup> First, the activities undertaken by the private persons must be "clearly articulated and affirmatively expressed as state policy."<sup>6</sup> For example, a state statute requiring a hospital to establish a peer review committee to "evaluate the qualifications and professional competence of persons performing medical and health care services,"<sup>7</sup> and to deny privileges to those determined to be unqualified, provides a clearly articulated and affirmatively expressed state policy whereby a decision to terminate a doctor's privileges, made pursuant to the statute, will satisfy the first prong of the test, even if that decision results in anticompetitive consequences.

The second prong of the test requires the conduct of the private persons to be "actively supervised by the state itself."<sup>8</sup> This prong requires that state officials have and exercise power to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy.<sup>9</sup>

The Court of Appeals, in assessing these two factors, concluded that the State of Oregon has a clearly articulated and affirmatively expressed policy favoring peer review and actively

supervises the peer review process through the State Health Division, Board of Medical Examiners and the state judiciary.<sup>10</sup> However, the Supreme Court disagreed, finding that the State of Oregon does not "actively supervise" peer review activities of hospitals. In finding no active state supervision, the Court concluded that Oregon's statutory scheme does not provide the State Health Division, Board of Medical Examiners, or the state judiciary with *ultimate authority* over private peer review determinations. Specifically, the statutory scheme does not provide any state official with the power to disapprove private privilege decisions.<sup>11</sup> The Health Division's statutory authority over peer review relates only to a hospital's peer review procedures; the Health Division has no authority to review the actual decisions made by peer review committees; the Board of Medical Examiners regulates the licensing of physicians in the State of Oregon and is notified of decisions to terminate or restrict privileges, but, it has no statutory authority to disapprove such decisions; likewise, while the state judiciary may indirectly review a private peer review decision during the course of a subsequent lawsuit, the judiciary has no statutory authority to review such decisions, and the Court concluded such review to fall far

short of satisfying the active supervision requirements. Absent active state supervision, the "state action" doctrine was not available to protect the peer review activities challenged by Dr. Patrick. Thus, the Court had no occasion to analyze whether the "state action" doctrine would apply if the physicians on the Hospital Peer review committee were found to have acted in bad faith.

**T**he significance of the actual holding in the *Patrick* case is lessened somewhat by the enactment of the Health Care Quality Improvement Act of 1986,<sup>12</sup> which immunizes peer review action taken "in the reasonable belief that [it] was in furtherance of quality health care." This statute had not been enacted at the time of the dispute in the *Patrick* case and thus was not applicable. Should the same factual situation as was present in the *Patrick* case arise in the future, however, this Act would come into play regardless of the applicability of the "state action" doctrine, and it would be up to the court to assess the reasonableness of the peer review activities involved.

### Conclusion

Although the Supreme Court failed to address the issue of whether "state action" immunity is available for bad faith conduct, the Court's holding is, nonetheless, important. The Court's rationale in finding no active state supervision broke new ground in "state action" analysis. In prior cases, lower courts often found the "state action" doctrine to be applicable in almost every situation where *any* statute existed which arguably could be viewed as constituting state supervision over peer review

activities. The *Patrick* case indicates that future courts will look more closely at the actual state legislation involved, requiring specific statutes satisfying the "active supervision" prong of the "state action" test before allowing the doctrine to shield peer review activities from antitrust liability.

### Notes

1. *Patrick v. Burget*, 1988-1 Trade Cas. (CCH) ¶67,997 (U.S. May 16, 1988).
2. *Id.* at 58,113.
3. *Patrick v. Burget*, 800 F.2d 1498, 1509 (1986).
4. *Patrick v. Burget*, *supra* note 1, at 58,114.
5. See, *California Retail Liquor Dealers Assn. v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980).
6. *Id.* at 105, quoting *Lafayette v. Louisiana Power & Light Co.*, 435 U.S. 389,410 (1978).
7. See, e.g., O.C.G.A. §31-7-15 (Supp. 1988).
8. *California Retail Liquors Dealers Assn. v. Midcal Aluminum, Inc.*, *supra* note 5, at 105, quoting *Lafayette v. Louisiana Power & Light Co.*, *supra* note 6, at 410.
9. *Patrick v. Burget*, *supra* note 1, at 58,115.
10. *Id.* at 58,115.
11. *Id.* at 58,115.
12. 42 U.S.C.A. §§11101-11152 (Supp. 1987).





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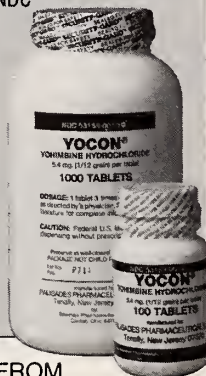
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#### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

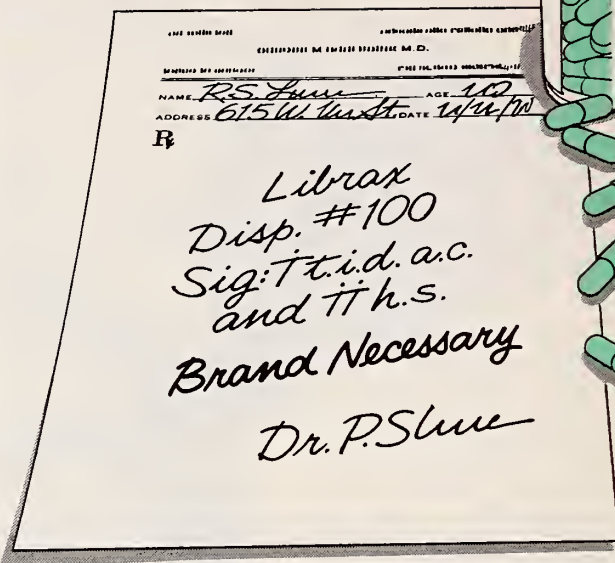
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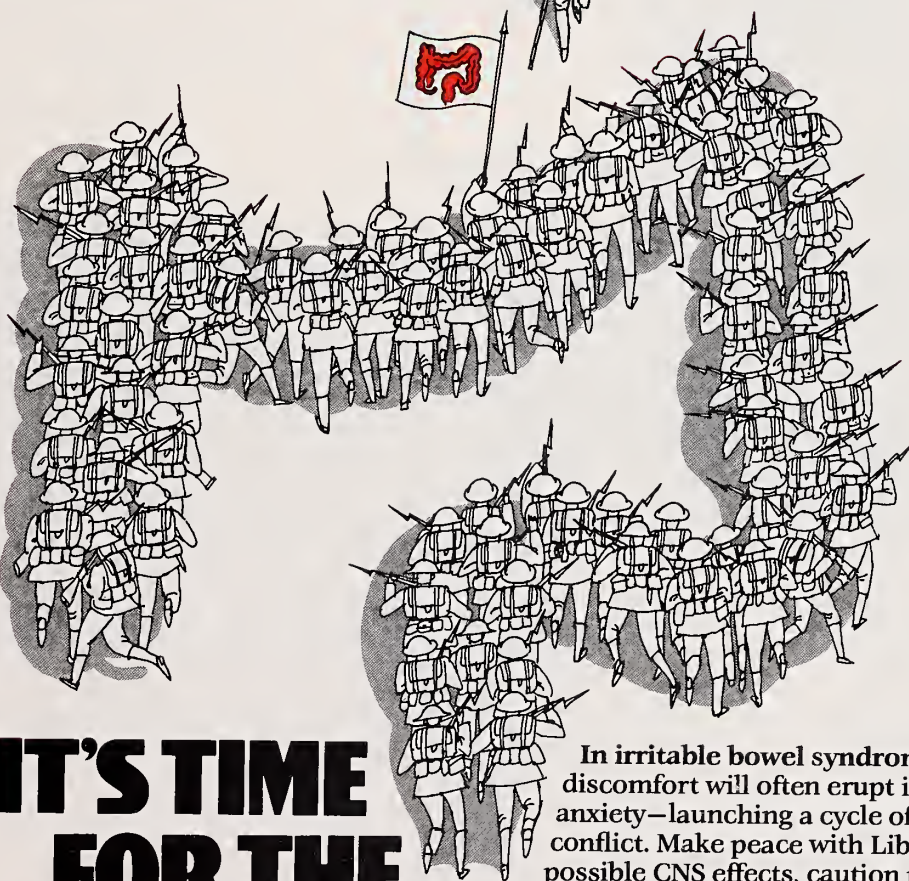
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Sorter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. *N Engl J Med* 1976;294:687-90.

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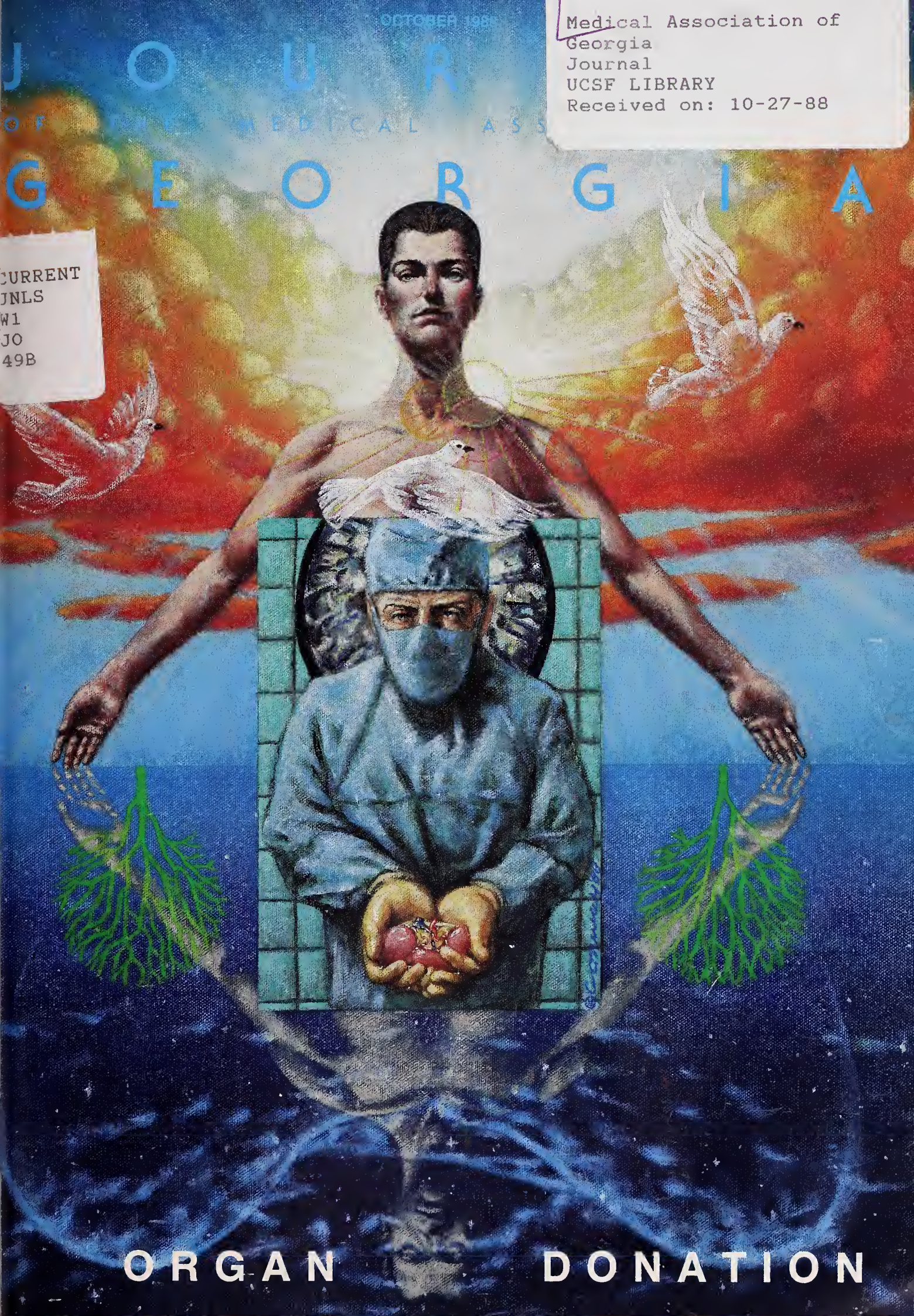
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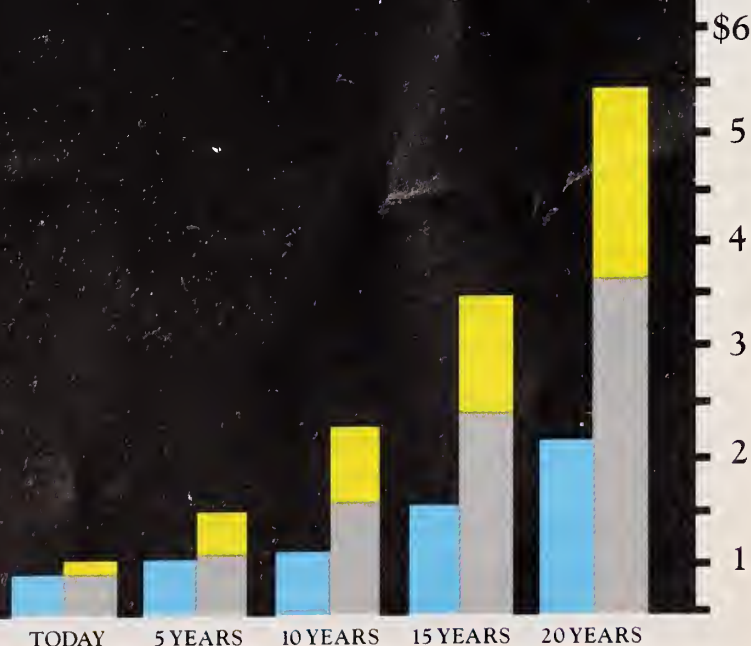
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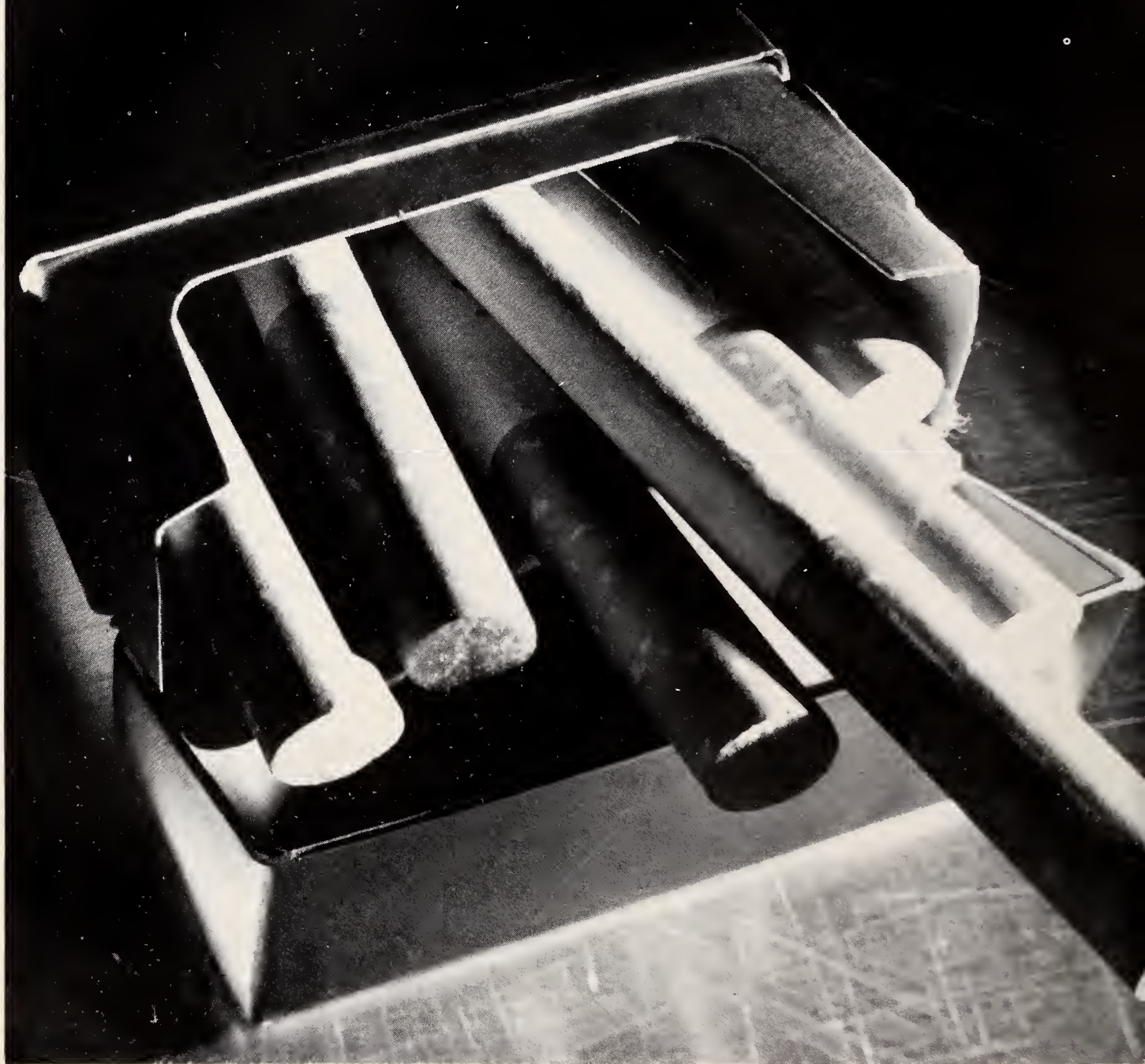
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**COVER**

The gift of life through organ donation when a loved one dies can be a source of strength for a grieving family. The cover painting by Augusta artist Tony Conway beautifully and poignantly communicates the central role of the physician as the vital link in the organ procurement process. Mr. Conway is a graduate of Parsons School of Design in N.Y.C. and currently completing studies at the Medical College of Georgia's Medical Illustration Program.

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Dear Editor:

I was disappointed to read your magazine's use of the word "wife" in its invitation for submissions to the "Quiet Thoughts" department. As a wife of a Georgia physician and a friend to two female physicians in our community, I remind you of the many, hardworking physicians in this state who are female, some of whom may have *husbands* who could submit material. In the future I hope to see the *Journal's* language reflect these facts by using the word "spouses," etc. Language sometimes has a way, intentional or not, of reflecting our biases and view of the world.

I look forward to watching the progress of the "Quiet Thoughts" page.

*Sincerely,  
Linda Browne  
Dalton*

*Ed. Note: We are aware of the sexual bias that often occurs in our language and do eliminate it when we catch it. This was one that got away. We sincerely regret this unintended, unfortunate, but, we hope, not unforgiveable error.*

Dear Editor:

I enjoyed reading your recent editorial in the July issue. I was particularly interested to see your quotation from Montaigne. I didn't know that there were any contemporary physicians who had ever read this author. I have read a few of his essays but certainly not all of them. I remember that he was described as being the wisest of Frenchmen.

From an editorial point of view, I want to mention the most common error I see and hear in everyday speech and even in well written presentations. I refer to the use of a singular subject with a plural pronoun or adjective following. I was dismayed and distressed to see that this had crept into your editorial near the end, where you mention the autonomy of the individual!

Please forgive my nit-picking. I guess I have become accustomed to your pride in excellent expression and construction in your writing.

It is interesting to find references to the classics in a medical journal. In time past, doctors were much more widely educated, for example, consider Sir William Osler.

It seems to me that you are doing an excellent job with the *Journal*, and I hope you continue for an extended time.

*With every kind regard,*

*Sincerely yours,  
Arthur G. Singer, M.D.  
Toccoa*

Dear Editor:

I enjoy the *Journal*, though retired, and am happy to see your planned Department, "Quiet Thoughts."

For some time now, I have been contributing a bit called "Poetry and Things" from Bynum's Scrap Book. They have gone hither and yon, and several have been published. I would like to contribute to "Quiet Thoughts" on a more or less regular basis, for what it's worth. And am enclosing my first "Thought." [Ed. note: See p. 693.]

I am a graduate of The Medical College of Georgia, in Augusta, class of '25. My father graduated from the same school in 1900. My wife is the daughter of the late Dr. Asbury Hull, and the granddaughter of the late great Dr. James Meriweather Hull. She is 77. I celebrated 86 one week ago today (August 8, 1988).

I have been keeping a scrapbook most of my life, mostly poetry and folklore. Even worked at it overseas (ETO) 1944-45, using cardboard and wrapping paper. I have three rather full books now. Constant reading of my material tends to help keep me young and happy.

My main sources of youth and happiness are my wife, Katharine H; friends; keeping busy with hobbies — reading, writing, and, yes — arithmetic, painting in oils, and wood-working. I do very little walking for walking's sake, but walk all day around my yard and my house — well, nearly.

I am a Life Member of The Fifty Year Club of Medicine. The last meeting I attended was two years ago in Chicago. I wasn't the oldest by any means. It was great.

With every good wish for your new Department, and EVERY Department.

*Sincerely,  
Richard Bynum Weeks, M.D.  
Saint Simons Island*

*The following comments were addressed to Dr. Harrison "Jack" Rogers, of Atlanta, who authored "Unity — Facing the RVS."*

Dear Jack,

I want to compliment you on your article in the July issue of the *Journal of MAG*. It was a masterful piece, and I hope you won't mind if I quote it on occasion, of course, with attribution. I would hope that others of your stature might be inclined to write similar articles in both their state and specialty organizations. We all know that physician reimbursement will not solve the problems of health care costs, but if we can get that issue off the table and move on to the other issue of volume and appropriateness we cannot help but occupy a higher level of esteem in the eyes of the public while, at the same time, making significant contributions.

*Cordially,  
James S. Todd, M.D.  
Senior Deputy Executive  
Vice President  
AMA, Chicago*

# The Future Effect Of AIDS On Your Insurance Plans

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The spectre of AIDS is casting a long shadow in the insurance community. Because of actual claims and expected claims, most nonguaranteed plans, and plans offered by companies that are not rock solid, will be severely affected. Unless you are positioned properly, you will see a doubling and tripling of your insurance rates,

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60-64	\$211.00	\$498.00

\*A+ Rated" Carrier  
as of 05-01-88  
\$250 Deductible

AGE	EMPLOYEE	FAMILY
Under 29	\$ 34.00	\$ 91.00
30-39	\$ 38.00	\$113.00
40-44	\$ 49.00	\$127.00
45-49	\$ 59.00	\$142.00
50-54	\$ 70.00	\$155.00
55-59	\$ 84.00	\$169.00
60-64	\$101.00	\$186.00

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**Skin and Skin Structure Infections** caused by *Escherichia coli*, *Klebsiella pneumoniae*, *Enterobacter cloacae*, *Proteus mirabilis*, *Proteus vulgaris*, *Providencia stuartii*, *Morganella morganii*, *Citrobacter freundii*, *Pseudomonas aeruginosa*, *Staphylococcus aureus* (penicillinase and nonpenicillinase-producing strains), *Staphylococcus epidermidis*, and *Streptococcus pyogenes*.

**Bone and Joint Infections** caused by *Enterobacter cloacae*, *Serratia marcescens*, and *Pseudomonas aeruginosa*.

**Urinary Tract Infections** caused by *Escherichia coli*, *Klebsiella pneumoniae*, *Enterobacter cloacae*, *Serratia marcescens*, *Proteus mirabilis*, *Providencia rettgeri*, *Morganella morganii*, *Citrobacter diversus*, *Citrobacter freundii*, *Pseudomonas aeruginosa*, *Staphylococcus epidermidis*, and *Streptococcus faecalis*.

**Infectious Diarrhea** caused by *Escherichia coli* (enterotoxigenic strains), *Campylobacter jejuni*, *Shigella flexneri*,\* and *Shigella sonnei*\* when antibacterial therapy is indicated.

\*Efficacy for this organism in this organ system was studied in fewer than 10 infections.

Appropriate culture and susceptibility tests should be performed before treatment in order to isolate and identify organisms causing infection and to determine their susceptibility to ciprofloxacin. Therapy with Cipro<sup>®</sup> may be initiated before results of these tests are known; once results become available appropriate therapy should be continued. As with other drugs, some strains of *Pseudomonas aeruginosa* may develop resistance fairly rapidly during treatment with ciprofloxacin. Culture and susceptibility testing performed periodically during therapy will provide information not only on the therapeutic effect of the antimicrobial agent but also on the possible emergence of bacterial resistance.

#### CONTRAINDICATIONS

A history of hypersensitivity to ciprofloxacin is a contraindication to its use. A history of hypersensitivity to other quinolones may also contraindicate the use of ciprofloxacin.

#### WARNINGS

**CIPROFLOXACIN SHOULD NOT BE USED IN CHILDREN OR PREGNANT WOMEN.** The oral administration of ciprofloxacin caused lameness in immature dogs. Histopathological examination of the weight-bearing joints of these dogs revealed permanent lesions of the cartilage. Related drugs such as nalidixic acid, cinoxacin, and norfloxacin also produced erosions of cartilage of weight-bearing joints and other signs of arthropathy in immature animals of various species (SEE ANIMAL PHARMACOLOGY SECTION IN FULL PRESCRIBING INFORMATION).

#### PRECAUTIONS

##### General:

As with other quinolones, ciprofloxacin may cause central nervous system (CNS) stimulation, which may lead to tremor, restlessness, lightheadedness, confusion, and very rarely to hallucinations or convulsive seizures. Therefore, ciprofloxacin should be used with caution in patients with known or suspected CNS disorders, such as severe cerebral arteriosclerosis or epilepsy, or other factors which predispose to seizures (SEE ADVERSE REACTIONS).

Crystals of ciprofloxacin have been observed rarely in the urine of human subjects but more frequently in the urine of laboratory animals. Crystalluria related to ciprofloxacin has been reported only rarely in man, because human urine is usually acidic. Patients receiving ciprofloxacin should be well hydrated, and alkalinity of the urine should be avoided. The recommended daily dose should not be exceeded. Alteration of the dosage regimen is necessary for patients with impairment of renal function (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION).

##### Drug Interactions:

Concurrent administration of ciprofloxacin with theophylline may lead to elevated plasma concentrations of theophylline and prolongation of its elimination half-life. This may result in increased risk of theophylline-related adverse reactions. If concomitant use cannot be avoided, plasma levels of theophylline should be monitored and dosage adjustments made as appropriate.

Antacids containing magnesium hydroxide or aluminum hydroxide may interfere with the absorption of ciprofloxacin, resulting in serum and urine levels lower than desired; concurrent administration of these agents with ciprofloxacin should be avoided.

Probenecid interferes with the renal tubular secretion of ciprofloxacin and produces an increase in the level of ciprofloxacin in the serum. This should be considered if patients are receiving both drugs concomitantly.

As with other broad-spectrum antibiotics, prolonged use of ciprofloxacin may result in overgrowth of nonsusceptible organisms. Repeated evaluation of the patient's condition and microbial susceptibility testing is essential. If superinfection occurs during therapy, appropriate measures should be taken.

##### Information for Patients:

Patients should be advised that ciprofloxacin may be taken with or without meals. The preferred time of dosing is two hours after a meal. Patients should also be advised to drink fluids liberally and not take antacids containing magnesium or aluminum concomitantly or within two hours after dosing. Ciprofloxacin may cause dizziness or lightheadedness; therefore patients should know how they react to this drug before they operate an automobile or machinery or engage in activities requiring mental alertness or coordination.

##### Carcinogenesis, Mutagenesis, Impairment of Fertility

Eight *in vitro* mutagenicity tests have been conducted with ciprofloxacin and the test results are listed below:

- Salmonella/Microsome Test (Negative)
- E. coli* DNA Repair Assay (Negative)
- Mouse Lymphoma Cell Forward Mutation Assay (Positive)
- Chinese Hamster V<sub>79</sub> Cell HGPRT Test (Negative)
- Syrian Hamster Embryo Cell Transformation Assay (Negative)
- Saccharomyces cerevisiae* Point Mutation Assay (Negative)
- Saccharomyces cerevisiae* Mitotic Crossover and Gene Conversion Assay (Negative)
- Rat Hepatocyte DNA Repair Assay (Positive)

Thus, two of the eight tests were positive, but the following three *in vivo* test systems gave negative results:

- Rat Hepatocyte DNA Repair Assay
- Micronucleus Test (Mice)
- Dominant Lethal Test (Mice)

Long-term carcinogenicity studies in animals have not yet been completed.

##### Pregnancy—Pregnancy Category C:

Reproduction studies have been performed in rats and mice at doses up to six times the usual daily human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ciprofloxacin. In rabbits, as with most antimicrobial agents, ciprofloxacin (30 and 100 mg/kg orally) produced gastrointestinal disturbances resulting in maternal weight loss and an increased incidence of abortion. No teratogenicity was observed at either dose. After intravenous administration, at doses up to 20 mg/kg, no maternal toxicity was produced, and no embryotoxicity or teratogenicity was observed. There are, however, no adequate and well-controlled studies in

## CONVENIENT B.I.D. DOSAGE

### Recommended dosage schedule

Infection Site*	Severity of Infection	Dosage
Respiratory Tract*	Mild/Moderate	500 mg B.I.D.
Bone and Joint*	Severe/Complicated	750 mg B.I.D.
Skin/Skin Structure*	Mild/Moderate	250 mg B.I.D.
Urinary Tract*	Severe/Complicated	500 mg B.I.D.
Infectious Diarrhea*	Mild/Moderate/Severe	500 mg B.I.D.

pregnant women. SINCE CIPROFLOXACIN, LIKE OTHER DRUGS IN ITS CLASS, CAUSES ARTHROPATHY IN IMMATURE ANIMALS, IT SHOULD NOT BE USED IN PREGNANT WOMEN (SEE WARNINGS).

#### Nursing Mothers:

It is not known whether ciprofloxacin is excreted in human milk; however, it is known that ciprofloxacin is excreted in the milk of lactating rats and that other drugs of this class are excreted in human milk. Because of this, and because of the potential for serious adverse reactions from ciprofloxacin in nursing infants, a decision should be made to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

#### Pediatric Use:

Ciprofloxacin should not be used in children because it causes arthropathy in immature animals (SEE WARNINGS).

#### ADVERSE REACTIONS

Ciprofloxacin is generally well tolerated. During clinical investigation, 2,799 patients received 2,868 courses of the drug. Adverse events that were considered likely to be drug related occurred in 7.3% of courses, possibly related in 9.2%, and remotely related in 3.0%. Ciprofloxacin was discontinued because of an adverse event in 3.5% of courses, primarily involving the gastrointestinal system (1.5%), skin (0.6%), and central nervous system (0.4%).

The most frequently reported events, drug related or not, were nausea (5.2%), diarrhea (2.3%), vomiting (2.0%), abdominal pain/discomfort (1.7%), headache (1.2%), restlessness (1.1%), and rash (1.1%).

Additional events that occurred in less than 1% of ciprofloxacin courses are listed below. Those typical of quinolones are italicized.

**GASTROINTESTINAL:** (See above), painful oral mucosa, oral candidiasis, dysphagia, intestinal perforation, gastrointestinal bleeding.

**CENTRAL NERVOUS SYSTEM:** (See above), dizziness, lightheadedness, insomnia, nightmares, hallucinations, manic reaction, irritability, tremor, ataxia, convulsive seizures, lethargy, drowsiness, weakness, malaise, anorexia, phobia, depersonalization, depression, paresthesia.

**SKIN/HYPERSENSITIVITY:** (See above), pruritus, urticaria, photosensitivity, flushing, fever, chills, angioedema, edema of the face, neck, lips, conjunctivae or hands, cutaneous candidiasis, hyperpigmentation, erythema nodosum.

**SPECIAL SENSES:** blurred vision, disturbed vision, (change in color perception, overbrightness of lights), decreased visual acuity, diplopia, eye pain, tinnitus, bad taste.

**MUSCULOSKELETAL:** joint or back pain, joint stiffness, achiness, neck or chest pain, flare-up of gout.

**SKIN/HYPERSENSITIVITY:** interstitial nephritis, renal failure, polyuria, urinary retention, urethral bleeding, vaginitis, acidosis.

**CARDIOVASCULAR:** palpitations, atrial flutter, ventricular ectopy, syncope, hypertension, angina pectoris, myocardial infarction, cardiopulmonary arrest, cerebral thrombosis.

**RESPIRATORY:** epistaxis, laryngeal or pulmonary edema, hiccough, hemoptysis, dyspnea, bronchospasm, pulmonary embolism.

Most of these events were described as only mild or moderate in severity, abated soon after the drug was discontinued, and required no treatment.

In several instances, nausea, vomiting, tremor, restlessness, agitation, or palpitations were judged by investigators to be related to elevated plasma levels of theophylline possibly as a result of a drug interaction with ciprofloxacin.

**Adverse Laboratory Changes:** Changes in laboratory parameters listed as adverse events without regard to drug relationship:

Hepatic—Elevations of: ALT (SGPT) (1.9%), AST (SGOT) (1.7%), alkaline phosphatase (0.8%), LDH (0.4%), serum bilirubin (0.3%).

Hematologic—eosinophilia (0.6%), leukopenia (0.4%), decreased blood platelets (0.1%), elevated blood platelets (0.1%), pancytopenia (0.1%).

Renal—Elevations of: Serum creatinine (1.1%), BUN (0.9%).

**CRYSTALLURIA, CYLINDRURIA, AND HEMATURIA HAVE BEEN REPORTED.**

Other changes occurring in less than 0.1% of courses were: Elevation of serum gamma-glutamyl transferase, elevation of serum amylase, reduction in blood glucose, elevated uric acid, decrease in hemoglobin, anemia, bleeding diathesis, increase in blood monocytes, and leukocytosis.

#### OVERDOSAGE

Information on overdosage in humans is not available. In the event of acute overdosage, the stomach should be emptied by inducing vomiting or by gastric lavage. The patient should be carefully observed and given supportive treatment. Adequate hydration must be maintained. In the event of serious toxic reactions from overdosage, hemodialysis or peritoneal dialysis may aid in the removal of ciprofloxacin from the body, particularly if renal function is compromised.

#### DOSAGE AND ADMINISTRATION

The usual adult dosage for patients with urinary tract infections is 250 mg every 12 hours. For patients with complicated infections caused by organisms not highly susceptible, 500 mg may be administered every 12 hours.

Respiratory tract infections, skin and skin structure infections, and bone and joint infections may be treated with 500 mg every 12 hours. For more severe or complicated infections, a dosage of 750 mg may be given every 12 hours.

The recommended dosage for infectious diarrhea is 500 mg every 12 hours.

In patients with renal impairment, some modification of dosage is recommended (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION).

#### HOW SUPPLIED

Cipro<sup>®</sup> (ciprofloxacin HCl/Miles) is available as tablets of 250 mg, 500 mg, and 750 mg in bottles of 50, and in Unit-Dose packages of 100 (SEE FULL PRESCRIBING INFORMATION FOR COMPLETE INFORMATION).

\* Due to susceptible strains of indicated pathogens. See indicated organisms in Brief Summary.

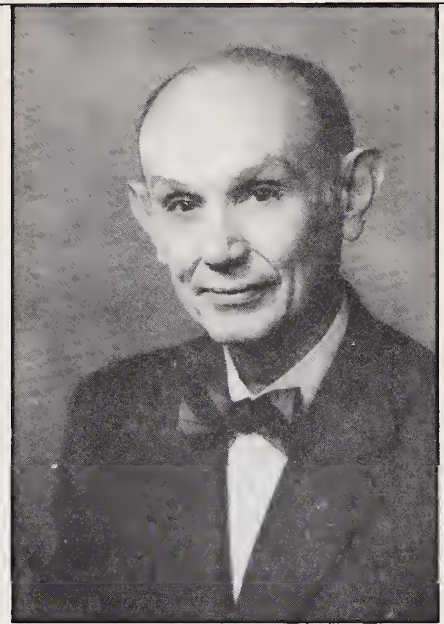
For further information, contact the Miles Information Service:  
1-800-642-4776. In VA. call collect: 703-391-7888.

## COMMITTED TO THERAPEUTIC EFFICIENCY



Miles Inc.  
Pharmaceutical Division  
400 Morgan Lane  
West Haven, CT 06516





*Joseph P. Bailey, Jr., M.D.*

**N**OW IS THE TIME to plan for participation in the 1989 Legislative Session for the State of Georgia. In so planning, it is of the utmost importance that you develop a relationship with your State Senators and Representatives. The mutual respect that can evolve from such activity will make it possible for your legislators to call on you for advice and for you to offer them your opinions about medically related issues. It is also highly valuable to medicine if you will participate in both the Doctor of the Day and Physician Involvement Programs during the Legislative Session.

Never before have we as a profession had so much attention from our lawmakers at both the State and National level. If we are not involved in influencing their actions you can be certain that others will be. I know that each of you share my concern for medicine's future. We are all dedicated to our patients' needs while simultaneously having to guard against further erosion of our position to have the wherewithal to meet these needs and those of our own families.

**I** do earnestly plead with each physician who reads these words to communicate with your legislators. Be certain that you know them but more importantly that they know you. Do this before you find it necessary to ask for their help. Your support of their efforts will never guarantee a positive response, but it most certainly will guarantee being heard as to your opinion.

We are in an age of change. Much of this change emanates from political influence. We cannot fail our profession by being at arms length with those who are integral to the process of legislative decision making.

*Joseph P. Bailey, Jr.*

## NEW MEMBERS

Bailey, Daniel H., Obstetrics/  
Gynecology — Thomas Area —  
(Active) 950 Fourth St., Cairo  
31728

Balsley, Robert S., Internal Med./  
Emergency Med. — Georgia  
Medical Society — (Active) P.O.  
Box 570, Savannah 31402

Brewton, Lloyd C., Radiology —  
Troup — (Active) P.O. Box 850,  
LaGrange 30240

Cohen, Steven L., Internal Med. —  
Douglas — (Active N2) 1001  
Thornton Rd., Box 36, Lithia  
Springs 30057

DeGross, Joseph M., Nephrology  
— Colquitt — (Active) 1317-A  
South Main St., Moultrie 31768

Dixon, Frederick E.,  
Cardiovascular Diseases —  
Whitfield-Murray — (Active)  
1436 Broadrick Dr., Ste. B,  
Dalton 30720

Dowling, Robert A., Urology —  
Crawford W. Long — (Active  
N2) 1010 Prince Ave., Athens  
30606

Erfe, Antonia M. — Crawford W.  
Long — (Active) Beaver Dam  
Dr., Winterville 30683

Greer, John A., Urology — MAA  
— (Resident) 1002 Biltmore  
Dr., Atlanta 30329

Guttman, David, Pediatrics —  
Decatur-Seminole — (Active)  
1605 E. Shotwell St., Bainbridge  
31717

Hardman, Norman C., Jr., Internal  
Med. — Whitfield-Murray —  
(Active N2) 1109 Burleyson Dr.,  
Dalton 30720

Hassanyeh, Akram M., General  
Surgery — Ogeechee River —  
(Active) P.O. Box 856, Metter  
30439

Holman, Ronald E.,  
Ophthalmology — Troup —  
(Active N2) 303 Smith St.,  
LaGrange 30240

Hudgins, Patricia A.,  
Neuroradiology — MAA —  
(Active N1) 1365 Clifton Rd.,  
Atlanta 30322

Hudson, William S., Psychiatry —  
MAA — (Active N2) 1938  
Peachtree Rd., Ste. 612, Atlanta  
30309

James, Robysina L., Orthopaedic  
Surgery — MAA — (Active N2)  
35 Butler St., Ste. 302, Atlanta  
30335

Johnson, Carl D., III, Family  
Practice — Tift — (Active N2)  
1824 N. Lee Ave., Tifton 31794

Johnson, J. Steven, Radiation  
Oncology — Thomas Area —  
(Active N1) 116 Mimosa Dr.,  
Thomasville 31792

Kabbani, Azmi, Internal Med. —  
Bibb — (Resident) 4241 Wood  
Forest Pl., Macon 31210

Kopchick, Margaret A.,  
Dermatology — Stephens-  
Rabun — (Active) 800 E. Doyle  
St., Toccoa 30577

Leblang, Michael, Family Practice  
— Georgia Medical Society —  
(Active) P.O. Box 23089,  
Savannah 31403

Lopez, Frank, Internal Med./  
Gastroenterology — Ware —  
(Active) 1921 Alice St.,  
Waycross 31501

Luke, Joseph P., General Surgery  
— MAA — (Active N2) 980  
Johnson Ferry Rd., Ste. 430,  
Atlanta 30342

Martin, Zack Z., Internal Med./  
Gastroenterology — Gwinnett-

Forsyth — (Active) 100 Med.  
Center Blvd., Ste. 130.,  
Lawrenceville 30245

Millner, Michael R., Radiology —  
South Georgia — (Active N2)  
207 DeOsta Dr., Valdosta 31604-  
3499

Nezhat, Farr R., Endocrinology —  
MAA — (Active N2) 5555  
Peachtree Dunwoody Rd., Ste.  
276, Atlanta 30342

Peacock, Lisa Marie, Obstetrics/  
Gynecology — MAA —  
(Resident) 811 Drewry St.,  
Atlanta 30306

Price, Kathleen N., Radiology —  
MAA — (Resident) 3090 Valley  
Cir., Decatur 30033

Ramsingh, Kulwant K., Nuclear  
Med./Radiation Oncology —  
Richmond — (Active) 3567  
Pebble Beach Dr., Martinez  
30907

Seltman, Marc A., Internal Med.  
— MAA — (Active N2) 1221  
Druid Oaks Dr., Atlanta 30329

Shapiro, Jeffrey D., Anesthesiology  
— MAA — (Active) 353  
Parkway Dr., Ste. 101, Atlanta  
30312

Turk, Althea L., Ophthalmology —  
MAA — (Associate) 970 MLK  
Jr., Dr., Atlanta 30314

Ward, Ann P., Endocrinology/  
Internal Med. — Floyd-Polk-  
Chattooga — (Active) P.O. Box  
139, Taylorville 30178

Williams, Robert L., Pediatrics —  
Stephens-Rabun — (Active) 800  
E. Doyle St., Toccoa 30577

*Be civil to all; sociable to many;  
familiar with few.*

BENJAMIN FRANKLIN



## MORE NEWS

### Family Practitioners, Internists & Obstetricians Needed

Public Health Departments in every area of the state need physicians who are willing to accept patients who test positive for antibodies to the AIDS (HIV) virus for routine care and follow-up.

Each month, approximately 125-150 HIV-positive individuals are identified in the public health testing clinics. They are counseled about being HIV infected and advised to see a physician for a complete examination and follow-up treatment. Many of them have no regular physician or are reluctant to go to their family physician. Most of them are asymptomatic and clinically well and only require counseling, regular follow-up, and routine care. Many will not become ill or need specialized care for 5 to 10 years.

The Office of Infectious Disease, Division of Public Health, Department of Human Resources, is compiling a list of physicians willing to accept referral of these patients. If you are interested, please respond in writing to:

Joseph A. Wilber, M.D.  
Medical Director,  
AIDS Projects  
Office of Infectious Disease  
878 Peachtree St.  
Atlanta, GA 30309  
(404)894-5307

*Fate laughs at probabilities.*  
EDWARD BULWER-LYTTON

## QUOTES

*Make friends and you will make greater progress. The way to make a true friend is to be one. Friendship implies loyalty, esteem, cordiality, sympathy, affection, readiness to aid, to help, to stick, to fight for. Friends are essential to success, they are still more essential to happiness. To win place, power, honor and happiness, begin by assiduously and unselfishly winning friends.*  
B.C. FORBES

*Talk is by far the most accessible of pleasures. It costs nothing in money, it is all profit, it completes our education, founds and fosters friendships, and can be enjoyed at any age and in almost any state of health.*

ROBERT LOUIS STEVENSON

*I never found the companion that was companionable as solitude.*  
HENRY DAVID THOREAU

*The more extensive a man's knowledge of what has been done, the greater will be his power of knowing what to do.*  
BENJAMIN DISRAELI

*Failure to accord credit to anyone for what he may have done is a great weakness to do.*  
BENJAMIN DISRAELI

*Misfortunes are like knives, that either serve us or cut us, as we grasp them, by the blade or by the handle.*  
JAMES RUSSELL LOWELL



Reuben S. Roberts, Jr., M.D. (left), of Hawkinsville, presents Rep. Newt Hudson a \$500 check for the "Rep. Newt Hudson Campaign Fund" from the Georgia Medical Political Action Committee. Rep. Hudson has been a good friend and supporter of MAG.

*A wise man will make tools of what comes to hand.*  
THOMAS FULLER

*Victories that are easy are cheap. Those only are worth having which come as the result of hard fighting.*  
HENRY WARD BEECHER

*The recipe for perpetual ignorance is: Be satisfied with your opinions and content with your knowledge.*  
ELBERT HUBBARD

*The worst handicap is to be unloved, the second worst handicap is to be unloving.*  
FRANK TYGER

## Georgia's Nursing Shortage Becomes More Acute

A new Georgia Hospital Association survey shows that the state's hospitals are experiencing a growing shortage of registered as well as licensed practical nurses and nurse's aides. The survey, which was taken for the week of Oct. 25, 1987, set the 1987 RN vacancy rate at 17.8%, compared to Georgia's 1986 vacancy rate of 13.8%.

Georgia's figures are higher than the national rate, which the American Hospital Association calculates at 11% for 1986 and 11.3% for 1987.

The growing demand for hospital nurses in Georgia was also seen in the actual number of vacancies. In 1986, with 187 hospitals responding to the GHA survey, about 3,000 vacancies were reported. Yet the 1987 survey, with only 133 hospitals responding, showed the number of vacancies still at about 3,000.

The vacancy rate for LPNs, measured at 5% in 1986, tripled to slightly higher than 15% in the 1987 study period, while the need for nursing assistants reached a 15.7% vacancy rate in 1987.

For non-nursing health care positions, hospitals reported a 14.6% vacancy rate, with the greatest need being for medical technologists, radiology technologists, and respiratory therapists.

## Hospital Association Participates In Health Careers Recruiting Across State

The Georgia Hospital Association is participating in a state-wide tour of secondary schools to promote health careers recruitment.

The tour, which is sponsored by the Georgia Education

Articulation Committee, is an annual event in which many Georgia colleges participate. This is the first year that it has included a program on health care careers in general.

At each presentation site on the tour, GHA representatives will set up a booth providing information on health careers in hospitals as well as other health settings.

## Hospitals Campaign To Protect Medicare

"Elect to Protect Medicare" is the theme of a new promotional program sponsored by the American Hospital Association to prevent further cuts in the Medicare program. The AHA's goal is to bring about 1.5 million congressional contacts by concerned voters during this year and next.

Hospitals throughout Georgia are participating in the effort through media contacts and by encouraging their employees and communities to contact their U.S. congressional representatives about the problem Medicare cuts are placing on hospitals.

According to AHA calculations, the cost of uncompensated hospital care in Georgia alone came to more than \$1 billion in 1986.

## Government Tightens The Purse Strings on Indirect Medical Education Costs

Continuing the ever-tightening squeeze on Medicare payments to hospitals, the General Accounting Office has advised Congress to cut payments for indirect medical education by 2.5% in FYs 1989 and 1990 — from 7.6% to 5.1%.

The cuts, says the GAO, would save \$1.6 billion during those years. The logic behind the proposal is a government estimate

that teaching hospitals saw a 10.5% Medicare profit in 1987, whereas non-teaching hospitals saw only a 2.9% profit during the same year.

## General Motors Now Looking at Hospital Costs

Hospital operations came under further scrutiny last month, this time from consumers.

The General Motors Corp. of Detroit has announced it has begun an audit of the 50 hospitals that provide the most care to its employees. The company is looking specifically at the appropriateness of length of stay, room and board charges, and the costs of ancillary services. Each of the hospitals chosen for the audit provides at least \$3.8 million in health care to GM employees each year.

Last year alone, GM spent \$3 billion on health care, and it reports that amount to be \$600 million more than its health care expenses in 1986.

## Hospitals to Receive HCFA's Mortality Rates This Month

By the end of this month, hospitals will receive their individual Medicare mortality rates compiled by the Health Care Financing Administration.

The government will allow institutions 30 days to respond to the data and will then include the comments in its release of the rates to the public. That release is expected to take place in December.

This is HCFA's third annual report of hospital-specific mortality data on Medicare patients.

*(This department is sponsored by the Georgia Hospital Association.)*



# CALENDAR

## OCTOBER

20-21 — *Atlanta: Interventional Radiology for Physicians.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

21 — *Atlanta: SLE Symposium — Update 1988.* Category 1 credit. Contact Andriette Ward, Office of CME, Morehouse School of Medicine, 720 Westview Dr., Atlanta 30310. PH: 404/752-1770.

21-22 — *Atlanta: Managing Preterm Labor & Electronic Fetal Monitoring.* AMA Category 1 and ACOG cognate credits. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

24-28 — *Atlanta: Modern Methods of Diagnosing and Treating Diabetes Mellitus and Its Complications.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

24-25 — *Atlanta: Quantitative Thallium Myocardial Tomography.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

27-28 — *Atlanta: Health Manpower Issues in Georgia and Alabama.* Category 1 credit. Contact Pauletta Graves, Office of CME, Morehouse School of Medicine, 720 Westview Dr., Atlanta 30310. PH: 404/752-1629.

31-Nov. 1 — *Atlanta: Health Care Needs of Today's Women.* Category 1 credit.

Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

31-Nov. 4 — *Atlanta: Magnetic Resonance Imaging.* Category 1 Credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

## NOVEMBER

4-6 — *Atlanta: Gastroenterology for Primary Care Physicians.* Category 1 credit. Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

6-9 — *Helen, GA: 25th Institute on Group Behavior and Group Leadership.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

7 — *Atlanta: Hyperalimentation.* Category 1 credit. Contact Donna Cannon, HCA West Paces Ferry Hospital, 3200 Howell Mill Rd., Atlanta, 30327. PH: 404/350-5600.

10-12 — *Atlanta: Georgia Academy of Family Physicians Annual Meeting.* AAFP prescribed and AMA Category 1 credit. Contact Camille Day, GAFF, 3760 LaVista Rd., Ste. 100, Tucker, 30084. PH: 404/321-7445 or 800/392-3841.

11-13 — *Sea Island: Georgia Obstetrical-Gynecological Society.* Contact Chester Lane, 69 Butler St., Atlanta, 30309. PH: 404/659-0289.

11-13 — *Atlanta: Medical Association of Georgia Scientific Assembly.* Category 1 credit. Contact Steve Davis, MAG, 938 Peachtree St., Atlanta, 30309. PH: 404/876-7535 or 800/282-0224.

14-18 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

## DECEMBER

3-4 — *Atlanta: Regional Anesthesia: Surgery, Obstetrics, and Pain.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

5-9 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

7-9 — *Atlanta: Nuclear Medicine Update: Infection, Renal and Cardiac Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

12-16 — *Atlanta: Modern Methods of Diagnosing and Treating Diabetes Mellitus and Its Complications.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

## The Experience

**“I had said to myself all week that the sheer convenience of the Thing made a visit into town a necessary effort in the ever continuing task of not missing anything in this one way trip through life.”**

I THOUGHT THE OTHER DAY of what I had been told of changing a light bulb in California. “How many people does it take?” “Three. One to hold the ladder, one to change the bulb, and one to savor the experience.”

That’s the way it was with the Democrats and their gathering in Atlanta this past summer. I had thought that one could read about it. Lord knows enough printer’s ink flowed onto paper in doing so. If not, the “visual media” flooded the airwaves to the point of tedium.

Wrong! Remember Thou the light bulb! Should one with serious intent wish to accurately grasp this accumulation of issue-motivated fellow beings, then he or she must have *experienced* it.

I had said to myself all week that the sheer convenience of the Thing made a visit into town a necessary effort in the ever continuing task of not missing

anything in this one way trip through life. And so we went, we political inactivists, into the maw of the city. It was a day of magic — warm with summer sun, dry from lack of rain, wet as time passed into evening and thus possessed with the same unpredictability of the trip into town.

We got there on MARTA. Remember, the Metropolitan Atlanta Rapid Transit Authority. It’s a bit like the Massachusetts Transit Authority (MTA). Too young for the Kingston Trio? Too bad. They wrote, and sang, a little tune called “Riding on the MTA.” It’s a happy little song about a fellow who got on the MTA and just kept riding round and round the endless tracks, being handed necessary supplies — sandwiches and the like — as he traveled by friends waiting in the station.

We should have done it. Gone round and round, that is. But, we exited at the Five Points Station. Up the escalator to great throngs of placard-bearing, flag-waving, button-festooned delegates, all espousing a personally held view of the manner in which grave matters of universal concern should be viewed.

“Save The Babies.”

“Nuke ‘em.”

“Get ‘em Duke.”

“Gays Have Rights, Too.”

“Save Our Forests.”

“Women Against Ladies.”

“Fetuses Have Rights, Too.”

Dear Lord, preserve us — “Docs For The Duke.”

They were all there: the radical

right, the radical left, the radical middle of the roaders, the “I think this,” the “I think that,” the “I am not sure what I think.” Everyone was present.

And there in the midst of the swirling, sweating, professing mob stood I. What did I believe? Who did I really think would make the best President of the Republic? Was abortion an issue at all? Were the Irrational Iranians worth worrying about? Is the deficit really a problem or a fiscal mirage? Do I *really* give a damn anyway?

I walked the streets, inhaled the odors, tasted the indecision, and gazed at the ever-changing vista. I tried with no success to remember what the last GaMPAC-AMPAC epistle said — something about involvement in the political process — contribute, vote. I tried, oh, how I tried, to *experience* it all.

It was soon over. We settled into the crowded MARTA train. Eighty-five cents from Peachtree Station to the Arts Center Station. Quite a change, mind you. Political chaos to artistic chaos. But, out of the central city at last. Out of the turmoil into the quiet and peace of the cultural oasis that Bob Woodruff had helped give to the City.

Where are we in this never-ending quest for consensus building in the nation? Are the PACS truly effective? Do they convey to those they represent a fair return on investment for influencing the decisions upon



those matters of interest to them? Do political conventions, as in Atlanta and New Orleans this summer, provide a method of expressing the will of the people or are they but a gathering of influence seekers and media elite? My conscious self found itself but little helped by the throng of people espousing a personally held view toward the myriad issues in question. Was I so ingrained, so rigid, with preconceived notions that no amount of persuasion could sway or impact them?

Well, we got out of it all right — home to peace, the papers, the T.V., the indecision. Home to ponder the *experience* in the days that followed. Home to ask myself if the person who had with singular effort brought his home state hazardously close to a socialized state of medicine as had any governor in the nation, racing ahead of those liberals of national stature we had so long feared and opposed, could he safely and effectively lead us into areas equally as threatening to our safety if not our survival. There were in Atlanta that day many who thought him possessed of such talents and capable of such feats. I wondered.

**W**e face a similar decision-making process ourselves, we of the Medical Association of Georgia, for in May, 1989, we shall choose that person who will be *our* President. We will make a choice — for once in some time it will not be made for us —

between two individuals seeking our presidency. Not so much flag waving, button festooning, or placard carrying surely, but nonetheless the questions we must ask ourselves appear strikingly similar to those I asked that afternoon in Atlanta. Does our candidate understand the issues? Will he be willing to or capable of reasonable compromise? Will he make a desirable and impressive representation of the MAG to the public? Will he pay attention to and consider my (our) feelings regarding issues or, with callous disregard armed with the power of office, plunge forward into the future with only his own concerns and opinions to guide him?

**‘They were all there: the radical right, radical left, the radical middle of the roaders. . . . And there in the midst of the swirling, sweating, professing mob stood I.’**

It seems to me that races, contested elections, are good for us. They show involvement, interest, concern, and a hundred other virtues which the unconcerned care not to experience. They force us out of the listless doldrums and demand that we ask questions. They

demand that we think. One of those two persons running for the Presidency of MAG will be seen as you and I in the eyes of the public for an entire year. His choice of clothes will reflect *our* taste. The cars he drives will reflect *our* values of money. The issues he defends, or opposes, *our* feelings and concerns about those we serve and live amongst. The maturity, judgment, and compassion — the character — he exhibits will reflect *our* maturity, *our* judgment, *our* compassion, and *our* character. He will be us.

**S**urely, and with effort, must we think about it. But then, not too deeply. Perhaps more in the form of casual reflection. More akin to the random thoughts that rise from nothingness as one comes home from work well done and sits to savor the first cool dusk of fall. Thinking can be dangerous. Joseph Conrad knew that. He told us in the preface to his novel, *Victory*.

*“... self assertion, ... the mere way of it, the trick of the thing, the readiness of mind and the turn of the hand that come without reflection and lead the man to excellence in life, in art, in crime, in virtue and for the matter of that, even in love. Thinking is the great enemy of perfection. The habit of profound reflection is the most pernicious of all the habits formed by the civilized man.”*

CRU

# MRI UPDATE

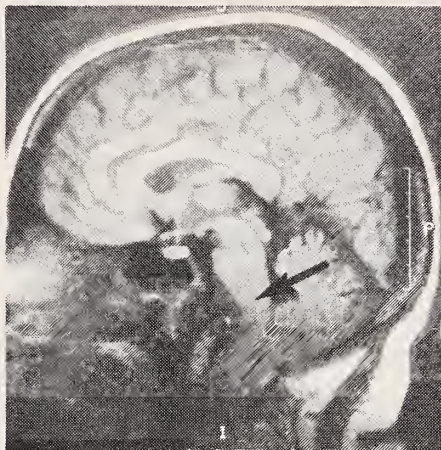


Figure A

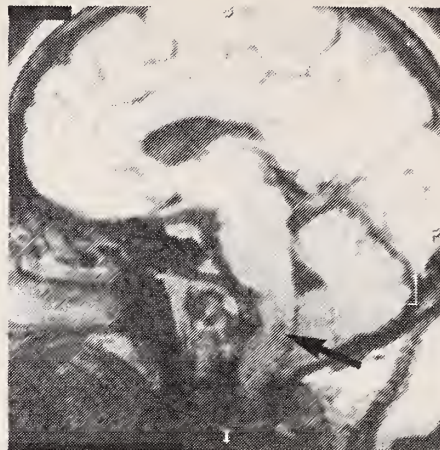


Figure B

**HISTORY:** This patient is a 31 year old female presenting with vertigo, tinnitus, and a history of forgetfulness for several months. The left corneal reflex was decreased, there were bilateral Babinski signs, and there was right leg weakness.

**SCAN:** Midline sagittal images demonstrate descent of the tonsils into the upper cervical canal. There is some compression of the posterior aspect of the tonsils. As there was no beaking of the tectum or other stigmata of an Arnold Chiari II malformation, this was considered to represent a Chiari I malformation.

A finding relevant to the patient's symptoms is an unusual posterior curvature of the odontoid (Fig. A, small arrow). Craniovertebral junction malformations are common in the Chiari I malformation although this particular variant is somewhat less common. The posterior aspect of the odontoid compresses the upper brainstem (Fig. A, large arrow). There is an area of low intensity within the caudal brainstem which appears cystic (Fig. B, large arrow).

## MRI HIGHLIGHTS:

This case demonstrates several advantages of MRI. Myelography at the craniocervical junction is usually difficult due to the tendency for contrast to spill over the clivus. Intrathecal contrast enhanced CT can demonstrate this area but has some morbidity. To obtain equivalent sagittal images thin contiguous overlapping CT slices would have to be obtained to derive an acceptable reformatted image. This can result in a considerable increase in radiation dose above that of a standard CT.



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## Transplantation: Today's Decisions

Kenneth E. Wheeler

***‘Saint Joseph’s Hospital’s decision to enter transplantation service represents the natural evolution of a religiously sponsored community hospital providing tertiary services. Its ability to deal with ethical issues presents a model of decision making for other institutions and medical staffs as such advanced programs come under consideration.’***

**I**T WAS GEORGE JAMES, M.D., then Dean, Sinai School of Medicine, New York, who observed in the 1960s that there were no less than six places on the island of Manhattan where the city’s poor could undergo open heart surgery, and none where they could get their teeth fixed. Decisions about how we as a

society and as a profession use and allocate resources continue to be with us and promise to be an evermore persistent concern as resources available to the healing professions continue to be limited.

Saint Joseph’s Hospital of Atlanta has a distinguished record of medical innovation dating to its origin as the city’s first hospital in 1880. The hospital’s decision in 1987 to enter the field of transplantation was characteristic of the continuing concern of the Sisters of Mercy who sponsor the hospital to balance our desire to provide better service to the sick with the need to use our resources effectively. To consider the feasibility of adding transplant services to its tertiary care services, the hospital management created a task force consisting of management, religious, and medical staff members. It was chaired by a physician on the medical staff. This group was charged with investigating the economics, facility and staff requirements, medical practice issues, and ethical questions surrounding transplantation.

The prominence of such a program led the hospital

immediately to seek the counsel of the Province of Baltimore, Sisters of Mercy. After reviewing the opportunities and issues as presented, the Province created three threshold questions for the task force to answer as a condition for Provincial consent to proceed with the program:

1. Demonstrate that the costs of the program do not require transplantation services to be priced out of reach of the ordinary citizen.
2. Demonstrate that the costs or subsidies of the program do not cause the hospital to eliminate or reduce any existing charity care services.
3. Demonstrate there is nothing inherent in the program which discriminates unfairly between recipient and donor.

These questions together with many more related to space and staffing requirements were answered as the task force proceeded. On June 25, 1987, the task force report to the hospital’s Board of Directors was approved, and on July 15, 1987, the first transplant was performed. The hospital completed a very thorough analysis from presentation of question through board approval, training of personnel, and operation in 56 days.

Mr. Wheeler is President/CEO of Saint Joseph’s Hospital of Atlanta, 5665 Peachtree Dunwoody Rd., Atlanta, GA 30342-1701. Send reprint requests to him.

**T**he role of universities and academic medicine, in addition to basic research and the pioneering of new technology, lies in diffusing new knowledge and skills to community institutions and practitioners. The success of community institutions in adapting these techniques and technologies to general community service is one indicator of quality of services available to the population.

Physicians and hospitals have observed the average acuity of patients in community hospitals rise as prospective payment and managed care programs have reduced utilization through shorter lengths of stay. This has left the patients in the hospital more acutely ill on the average than before. The role of the community hospital and the university hospital begin to merge

in the tertiary community hospital which provides specialty physician service and sophisticated diagnostics and treatment facilities convenient to the patient's location.

**S**aint Joseph's Hospital's decision to enter transplantation service represents the natural evolution of a religiously sponsored community hospital providing tertiary services. Its ability to deal with ethical issues presents a model of decision making for other institutions and medical staffs as such advanced programs come under consideration.

The hospital's experience to date with the resource demands of the transplantation program has been positive. The proforma analysis done in advance showed a start up loss with the program.

The Board of Directors approved the program, recognizing the economic risk because it found it important to demonstrate the hospital's commitment to community service through universal access. No patient is denied access to service at Saint Joseph's Hospital for lack of ability to pay. A larger level of activity than expected has brought the program closer to breakeven.

Additionally, the Board's decision anticipated a level of clinical success which has been surpassed. A community hospital works hard for its reputation and places that reputation on the line with caution. Only when the task force report convinced the Board that the quality of service and the success ratio in the program was achievable did the Board make that level of commitment to this community. ■

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# Quiet Thoughts

*"Whether therefore you eat or drink or whatever You do,  
do all to the glory of God"*

I CORINTHIANS 30-31

**A**RCHIBALD RUTLEDGE tells, in one of his books, of a Negro ferryman who ran his boat on a South Carolina river. The author, knowing how unkempt most of such craft are allowed to be, was delightfully surprised to find the engine of that vessel spotless and shiny and every appointment shipshape. He inquired of the man how it came about that he kept everything clean and neat, and his reply was, "I got a glory."

Berton Braley has taken the cue and confronted our consciences with it thus:

"Oh, you gotta get a glory  
in the work you do;  
A hallelujah chorus  
in the heart of you.  
Paint or tell a story;  
sing or shovel coal,  
But you gotta get a glory,  
or the job lacks soul.

Oh, Lord, give me a glory,  
And a workman's pride,  
For you gotta get a glory  
Or you're dead inside!"

*Richard Bynum Weeks, M.D.  
Saint Simons Island*

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# Organ and Tissue Procurement

*A limiting factor in health care for Georgians*

John D. Whelchel, M.D.

**D**URING THE PAST DECADE, major advances in immunosuppressive techniques and methods of immune modification have increased the success of organ transplantation. Presently, there are 224 hospitals with vascular organ transplant programs in the United States.<sup>1</sup> This number is expected to multiply as tertiary care hospitals view transplantation as a way to fill empty beds, boost their prestige in the medical community, and project a positive consumer image. This increase is occurring despite a persistent shortage of cadaver organs, with resulting struggles over the allocation of these limited resources. Hopefully, future advancements may lead to the successful utilization of primate tissues or artificial devices to reduce the growing demand for cadaver organs. However, such alternative solutions are highly experimental, and their possible clinical application remains on the distant horizon. Thus, the present shortage of cadaver organs and tissues will continue. The reduction

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**In 1987, the Georgia legislature passed "required referral" legislation mandating that all hospitals in Georgia initiate relationships with the state's organ and tissue procurement agencies and establish methods of referring all potential organ and tissue donors for consideration of donation.**

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of this shortage will require the commitment of physicians and the public toward increasing organ donation.

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## Organization

In addition to public participation, the correction of the disparity between the need for and the supply of cadaver organs requires the development and implementation of improved procurement efforts. In 1976, the Centers for Disease Control (CDC) in Atlanta, Georgia, collaborated with the Emory University School of Medicine and the Medical College of Georgia to study the effect of an organized regional cadaver organ procurement program on kidney donation. The results of this effort indicated an eight-fold increase in organ donation over the 3-year period of study.<sup>2</sup> Similar organ procurement efforts in the United States and abroad, staffed by fulltime procurement personnel, confirmed the CDC report.<sup>3,4</sup>

**F**ollowing completion of the CDC study in 1979, two programs were developed to provide organ procurement services in Georgia. One was an independent procurement agency, the Atlanta Regional

**TABLE 1 — Organ Donor Review Chart: Major factors for consideration in single or multiorgan donations**

	<i>Kidney</i>	<i>Heart</i>	<i>Liver</i>	<i>Pancreas</i>
Age	1-65	0-45	0-55	1-60
No active infection	important	important	important	important
No organ disease	mandatory	mandatory	mandatory	mandatory
No history of communicable disease	mandatory	mandatory	mandatory	mandatory
Hypotension	sensitive	very sensitive	very sensitive	sensitive
Vasopressors, i.e. dopamine sensitive	yes	very	very	yes
Weight important	no	yes	yes	no
Physical build	no	yes	yes	no
Additional MD consults required	rare	yes	rare	rare
Laboratory tests	kidney specific	heart specific	liver specific	pancreas specific
Additional time need to set up teams	no	yes	yes	yes

Organ Procurement Agency [now LifeLink of Georgia], and the other was established by the Medical College of Georgia in Augusta. Geographically, the Atlanta based program covers the north and mid-western portions of the State and the Medical College's program the remainder.

Both programs use nurses and/or physician's assistants trained in organ procurement and preservation techniques to coordinate organ donations with community hospitals and physicians. The programs promote organ donation through public and professional education endeavors throughout the state. Through the United Network for Organ Sharing (UNOS), these programs maintain local and national cadaver recipient waiting lists and assist the transplant centers in identifying suitable recipients for available organs.

Tissues, i.e., transplantable bone and skin, are procured by divisions or affiliates of the two previously mentioned procurement organizations in Atlanta and Augusta. Eye procurement is performed by the Georgia Lions Eye Bank, Inc, and the Eye Bank of the Medical College of Georgia. Similar to cadaver organs, the state's supply of tissue and

eyes is consistently less than area patient need.

The End Stage Renal Disease Act passed by Congress in 1974 provided funding for procurement programs in the United States. Further legislation in 1986 and 1987 required that all procurement programs be (1) non-profit organizations, (2) audited annually, (3) members of the United Network for Organ Sharing, and (4) approved by the Department of Health Care Financing Administration.

#### **Donor Selection and Management**

The ideal organ donor is a person less than 40 years of age who has suffered brain death, remains hemodynamically stable on artificial support systems, has no evidence of significant pre-existing illness or organ dysfunction, and is free of infection, communicable diseases, or extra-cranial malignancy. Since the majority of lethal brain injuries are the result of trauma, seldom is the ideal donor encountered. Thus, in many instances, compromise may be necessary. Careful and timely management, however, can convert a marginal potential donor to a suitable or ideal candidate.

Donor selection criteria depend on the organ or organs desired and the urgency of the potential recipient. Most heart, heart-lung, liver, and pancreas transplant teams prefer donors of age from newborn to 40 years. Older patients in excellent physiologic condition may be acceptable if there is no evidence of dysfunction in the specific organ of interest. Donors of these organs must be brain-dead, hemodynamically stable, and maintained on a ventilator until procurement is completed, i.e., "heart beating cadavers." The age range for renal donors is generally 1 to 55 years. Again, older, excellent physiologic donors may be acceptable. The majority of renal transplant programs prefer "heart beating cadaver" donors but with prior preparation, kidneys may be occasionally procured from "non-heart beating" donors. Specific and general factors considered in the selection of donor organs are included in the Organ Donor Review Chart (Table 1).

Management of the potential cadaver donor begins with a detailed history of the events leading to the donor's death, the medical treatment of these events, the physical injuries present, and a past medical history. These data are necessary



for evaluation of organ function and the preparation of a donor management plan. The primary objective in the management of a potential donor is to ensure optimal function of the desired organ or organs by maintaining hemodynamic stability and adequate ventilation. Management may require correction of hypovolemia with appropriate fluids, blood or blood products, maintaining adequate ventilation, and careful administration of agents such as catecholamines, diuretics, Pitressin, and electrolytes. Volume replacement and low dose catecholamines will usually provide adequate blood pressure in the potential donor. Vasopressor drugs such as Levophed and high dose catecholamines should never be used for blood pressure support over prolonged periods. These agents will shunt blood away from the organs of interest with resulting ischemic damage.<sup>5</sup>

Laboratory, radiologic, and other diagnostic procedures may be required to determine the functional status of the desired organ (Table 1). Aggressive anesthetic and hemodynamic management of the donor is necessary before and during the procurement procedure to improve the probability of obtaining a satisfactory organ for transplantation.<sup>6</sup>

Tissue donor requirements are less stringent than that of organ donors in that these procurements do not require the donor be "heart beating" and can take place hours following cessation of cardiac function. The absence of systemic infection, communicable disease, and extra-cranial malignancy is necessary. The age of the donor varies according to the tissues donated, with bone being from 17-65 and eyes, any age.

### Organ Procurement Techniques

Presently, most organ procurement procedures are carried out in the operating room of the donor's hospital. The general exception is heart-lung donation which may require transfer of the donor to the transplant hospital where the or-

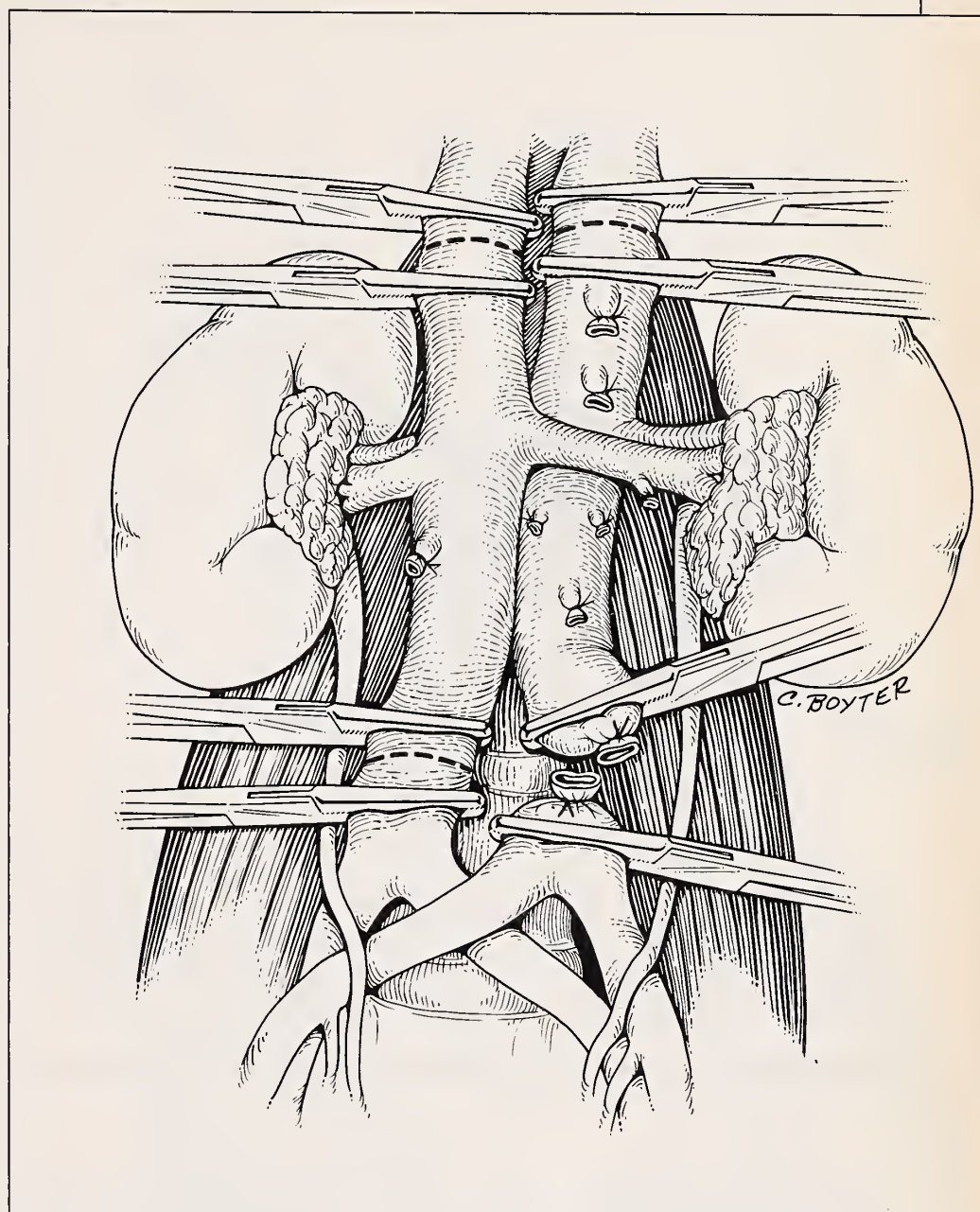
gans can be removed at the same time the recipient is being prepared. Kidney excision is now performed by community physicians in most regions of the nation, whereas liver, heart, and pancreas excisions are performed by a surgical member of the receiving transplant team.

The surgical technique or organ procurement is usually dependent on the number of organs donated. A midline incision extending from the sternal notch to the symphysis pubis allows adequate exposure for

the removal of all presently transplanted organs.

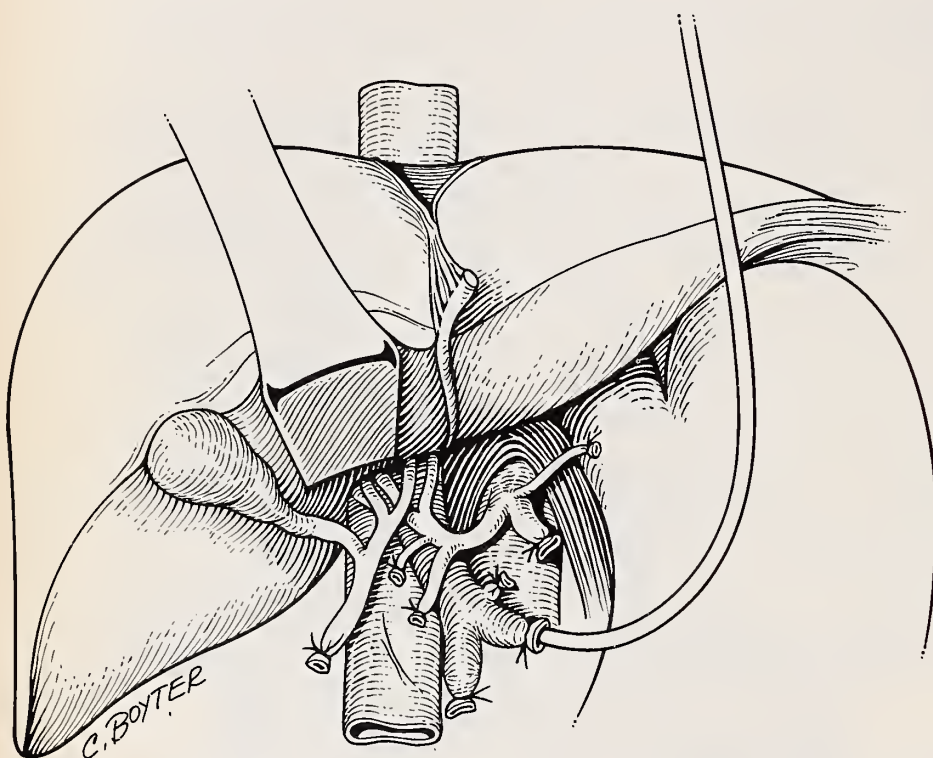
The standard method of cadaver kidney procurement is an en-bloc removal of both kidneys, ureters, the abdominal vena cava and aorta (Figure 1). The renal vessels initially remain attached to the cava and aorta. Division of the kidneys and vessels is performed on a back table under hypothermic conditions.

Liver procurement requires the careful dissection of the common bile duct, hepatic and celiac arter-



*Figure 1. En bloc dissection for cadaver nephrectomy. The kidneys are later flushed with preservation solution via the aorta.*





*Figure 2. En bloc cadaver donor liver preparation including the intact arterial supply, portal vein and vena cava segments necessary for transplantation. The liver is flushed with preservation solution via the hepatic artery and portal vein.*

ies, with care being taken to preserve any anomalous arterial supply, the portal vein, the inferior and superior hepatic vena cava, and the liver (Figure 2). The liver is initially perfused with hypothermic preservation fluid through the portal vein then via the hepatic artery. The vessels and common bile duct are divided at anatomically strategic points, and the liver is removed. Further dissection and preparation of the vascular structures and common bile duct are performed on a back table under hypothermic conditions.

Both total and segmental pancreatectomies have been used to procure pancreatic tissue for transplantation. Segmental pancreatectomy requires transection of the pancreas at its neck, with division

of the splenic artery near the celiac artery and the vein near the portal vein. Total pancreatectomy requires the removal of an intact celiac-hepatic-pancreatic-duodenal arterial arcade, the splenoportal venous system, and a cuff of duodenum containing the papilla of Vater. Liver and total pancreas procurement cannot be performed together.

Heart procurement requires the dissection of all great vessels of the heart. Hypothermic cardioplegia solution is infused retrograde into the coronary vessels through the proximal aorta for core cooling, and cold saline is placed in the open pericardium for surface cooling of the heart. All the great vessels are divided (Figure 3), and the heart is packaged for transportation.

En-bloc dissection of the heart-lung specimen requires mobilization of the aorta, inferior and superior vena cava, and the trachea. Total donor hypothermia is then initiated using the cardio-pulmonary bypass perfusion machine. Simultaneously with the infusion of cold cardioplegia solution via the proximal aorta, the lungs are perfused by infusing cold preservation solution into the pulmonary arteries.

### Organ Preservation

Two methods of organ preservation are now used in the clinical setting of organ transplantation: simple hypothermic storage and pulsatile perfusion. Simple hypothermic preservation after a brief "flush" of the organ with a hypothermic, hyperosmolar, high potassium, and low sodium perfusate is presently the simplest and most commonly used method for cadaver renal preservation.<sup>7</sup> Successful preservation periods with this technique of up to 50 plus hours have been reported; however, the average desired time is 24-36 hours. Delayed or non-function rates as a result of acute tubular necrosis increase with preservation periods

**Two methods of organ preservation are now used in the clinical setting of organ transplantation: simple hypothermic storage and pulsatile perfusion.**

exceeding 24-30 hours. Liver preservation by simple hypothermic means with Eurocollins II solution is limited to a maximum "safe" period of 8 hours. Recently, Belzer<sup>8</sup> has reported the successful 24-hour preservation of human livers using



the University of Wisconsin Preservation Fluid. Cardiac preservation after cardioplegic "flush" is limited to a period of approximately 4 hours of hypothermic storage in the clinical setting.

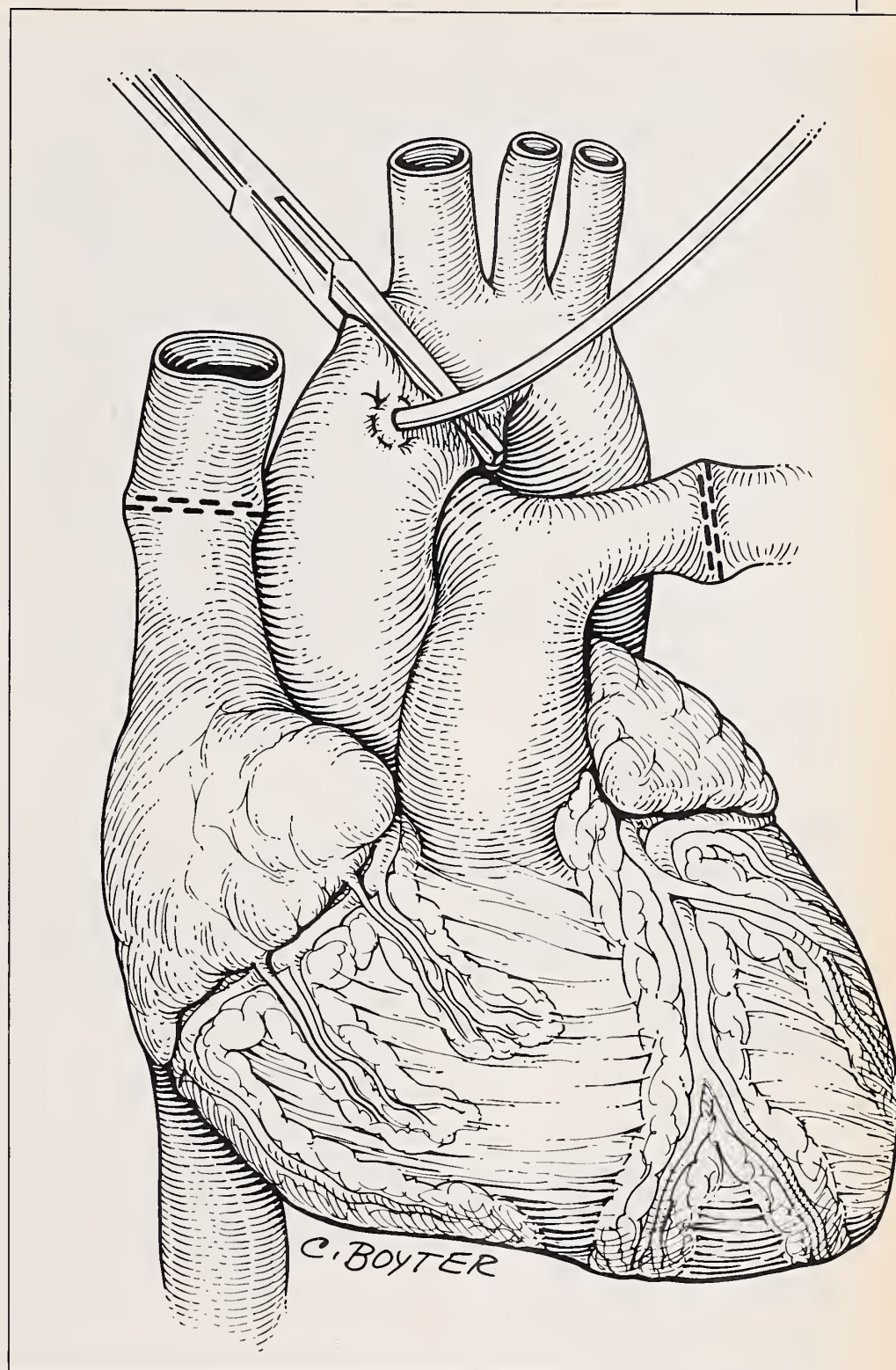
Continuous hypothermic pulsatile machine perfusion, initially developed by Belzer and associates,<sup>9</sup> using perfusates that are oxygenated and contain albumin, electrolytes, and various substrates, has successfully extended the preservation of human kidneys for periods in excess of 50 hours. However, this technique is more costly and complicated than simple hypothermic storage, with no statistical evidence of improvement in the quality of preservation under 30 hours.<sup>3,7</sup> Perfusion preservation has been studied experimentally for other organ systems, but in general this technique has not improved either the quality or length of time of successful preservation over that presently achieved by simple hypothermia.

### Tissue Preservation

Bone and skin may be preserved at temperatures slightly above freezing when immediate use is planned or by cryopreservation techniques for long-term preservation. Small bone segments can be freeze dried and stored for use "off the shelf."

### Procurement and Transplantation Activity in Georgia

In the past 3 years, 566 kidneys, 118 hearts, 94 livers, 14 pancreases, and 4 heart-lungs have been procured by the state's two organ procurement agencies. As a result of this activity, the state's organ transplant programs have transplanted 641 renal, 118 heart, 34 liver, and 3 heart-lung recipients in this period. Despite these numbers, over 600 Georgians now await cadaver kidneys, 50 await cadaver hearts, and 10 await cadaver livers. The waiting list will continue to grow as the rate of patients developing end-



*Figure 3. En bloc dissection of a cadaver heart with placement of the aortic preservation solution perfusion catheter. The great vessels are divided as the final step in excision.*

stage organ disease will exceed the present rate of donation. This shortage need not be, as there are adequate numbers of potential donors

in Georgia each year to supply the needed organs. In 1975, CDC's study indicated that there were a minimum of 52 excellent donors per



million population in Georgia each year.<sup>2</sup> Thus, in 1987, there were over 300 ideal organ donors who died in Georgia hospitals. Potentially 600 kidneys, 300 hearts, and 300 livers and/or pancreases were available last year. Unfortunately, in 1987 only 110 Georgians became organ donors. This discrepancy is due in part to lack of public education and participation, lack of physician support, and lack of hospital participation in the donor program. Georgia's potential transplant recipient needs will not be met through regional sharing, as the organ and tissue shortage is a national problem.

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**The primary objective in the management of a potential donor is to ensure optimal function of the desired organ or organs by maintaining hemodynamic stability and adequate ventilation.**

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In 1986, the Georgia legislature passed "required referral" legislation mandating that all hospitals in Georgia initiate relationships with the state's organ and tissue procurement agencies and establish methods of referring all potential organ and tissue donors for consideration of donation. Medicare also requires that hospitals have working agreements for cadaver donor referral with organ procurement programs. Many, but not all, Georgia hospitals have responded favorably to both the state and Medicare requirements. However, overall physician support for organ donation and public participation continues to lag behind hospital commitment.

### **Issues**

For many reasons, improvement in patient survival following organ transplantation has encouraged an increasing number of tertiary hospitals to establish organ transplant programs. During 1987, approximately 11,500 kidney, liver, and heart transplants were performed in the transplant programs of 224 U.S. hospitals. Despite these numbers, at the end of 1987, over 12,000 patients awaited the availability of cadaver organs. Ninety percent of these patients await cadaver kidneys. Of the 1000-plus awaiting hearts or livers, approximately one-third will die before suitable organs are donated.<sup>1</sup>

In general, the interest in establishing organ transplant programs has not been accompanied by an equal interest in increasing organ donations. Thus, nationally, the number of patients receiving transplants has not proportionately increased in relation to the growing number of transplant programs. In 1987, only 10-14% of the estimated 23,000 brain deaths in the United States resulted in organ or tissue donations.<sup>1</sup> Therefore, the supply of organs and tissues, not transplant facilities, continues to be the major limiting factor in the clinical use of transplantation to improve or extend life.

The present shortage of cadaver organs has resulted in passionate pleas for donation through the news media instigated by the families of those in critical need. As these publicized pleas were specifically answered, less fortunate individuals awaiting cadaver organs inspired "investigative reporters" and many legislators to assume the absence of a fair and equitable system for organ distribution. In 1986, a Task Force on Organ Transplantation appointed by Congress to study national procurement and transplant needs issued a report<sup>10</sup> which included the following recommendations: (1) required request legislation to mandate that all potential donor families be offered the opportunity to donate in all 50 states; (2) a national organ sharing network be established; (3) equitable

access of all patients to transplantation through federal funding of transplant procedures be assured; (4) prohibit commercialization in the distribution of organs; and (5) limit the current wave of expansion of transplant centers.

Several issues addressed by these recommendations have been acted upon in part, while others, such as equitable access through federal funding, remain unresolved. UNOS was awarded the federal government contract to establish criteria for approving organ transplant centers that receive federal funds and devising a fair and equitable organ sharing system. This Agency is presently struggling with the many complex local, regional, and national issues in organ procurement

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**Through the United Network for Organ Sharing, these (2 Georgia) programs maintain local and national cadaver recipient waiting lists and assist the transplant centers in identifying suitable recipients for available organs.**

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and distribution brought about by area need and competitive demand for these limited donor resources.

Legal concerns pertaining to donation remain an obstacle for many hospitals and physicians. The federal and Georgia Uniform Anatomical Gift Acts were passed to alleviate many of these concerns, but doubt still lingers. Although several courts have upheld the diagnosis of death based on brain death criteria, the acceptance of the concept of "brain death" remains a debated is-



sue. Required request legislation for organ donation has not been generally well received by hospitals or medical communities (Georgia requires only referral).

Lack of public understanding and participation in the organ donor program remains a major limiting factor to increasing organ donation. A recent survey conducted by the Georgia Chapter of the Public Relations Society of America revealed that 83% of the Georgians were aware of organ donation, and 60% agreed with the concept of brain death. Twenty-five percent claimed to be organ donors and to have signed organ donor cards. Of those surveyed who had made no such decision (non-donors), 44% indicated they might consider being an organ donor at the time of their death, whereas 50% indicated they would not be donors. Fifty-two percent of all Georgians surveyed indicated that they would likely give permission for the donation of a family member's organs. Twenty-five percent of those surveyed indicated they did not know how to become a donor, and 50% indicated they did not have enough information about organ donation to make a decision. Forty percent of the surveyed group indicated they felt their doctor would be their preferred source for information about donation, and 21% would turn to their local hospitals. Fifty percent of those surveyed felt that hospitals should be required by law to ask families of dead or dying patients to donate those patient's organs. While this survey indicated most Georgians are aware of transplantation and organ donation, the majority of responses indicated a need for more information and a large percentage who did not wish to be donors. Thus, there is an obvious need in Georgia for increased efforts in public education to improve participation in the donor program.

A survey of 5000 Georgia physicians was attempted, with a response rate of only 12%. The majority responding (88%) were aware of the critical need for donor organs and tissues. Of these physicians, 75% had positive attitudes toward

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**Skin**

personal donation, 62% indicated they had discussed organ donation with their families, and 84% felt that organ donation should be suggested to every family member of a potential donor. Unfortunately, only 54% of responding physicians indicated they knew how to contact a donor agency. Approximately 30% felt they were not legally protected from lawsuits arising from the donation process. Of interest, specialists in family practice and internal medicine showed the highest level of interest in the donor program and willingness to inform their patients.

**Summary**

Advancements in surgical techniques and immunosuppression therapies have increased the success of organ and tissue transplantation. Such procedures as corneal, bone, kidney, liver, and heart transplants are now clinically acceptable methods of replacing injured, diseased or "worn-out" tissues to improve and/or extend patients' lives. During the past 3 years, the transplant facilities and procurement organizations in this state have

expanded their activity in an attempt to meet the growing need of Georgia patients for their services. Unfortunately, the ability to increase the number of transplants performed remains limited by the availability of donor organs and tissues. Improvement in the present supply of organs and tissues will require greater participation of both the public and physicians in encouraging donation at the time of death. Until widespread participation in the donor program occurs, Georgians will continue to wait increasing periods of time for gifts of sight, rehabilitation, or life through organ and tissue transplantation.

**Acknowledgement**

The public and professional survey report on attitudes of Georgians about organ donation conducted by the Public Relations Society of America, Georgia Chapter, and the Strategic Research Center of Atlanta was made possible by a grant to LifeLink of Georgia from the Piedmont Dialysis Center of Dialysis Clinics Incorporated, Atlanta, Georgia.



The author expresses appreciation to LifeLink of Georgia and The Medical College of Georgia's Organ Procurement Program for organ procurement and transplantation data.

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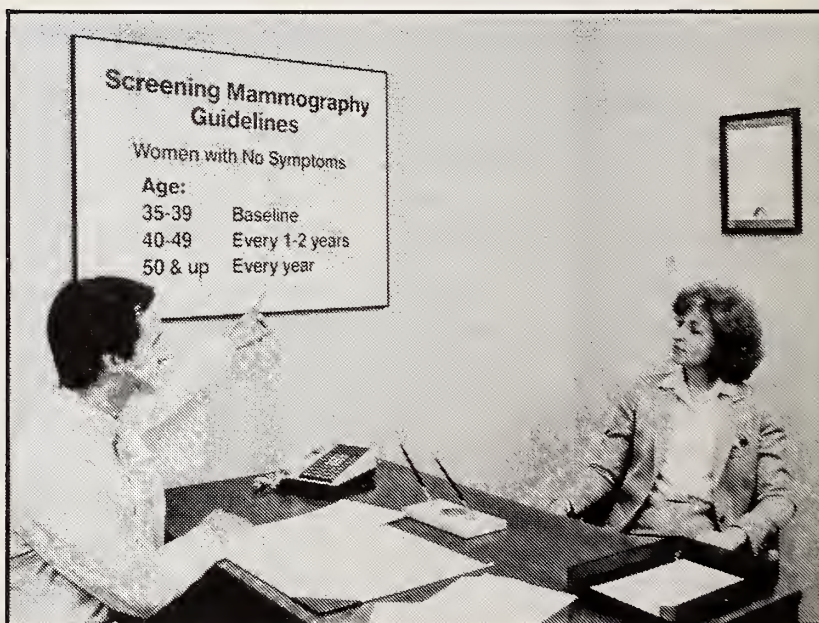
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# Georgia's Two Organ Procurement Programs

Arthur L. Humphries, Jr., M.D., Mary Anne House, R.N., M.S.N.,  
James J. Wynn, M.D., P. Allen Bowen, II, M.D.

## Introduction

**T**WENTY YEARS AGO, William van Burren was given a heart transplant. Today, he plays with his grandchildren.<sup>1,2</sup> It has been 20 years since brain death was defined<sup>3</sup> and neurosurgeons were first encouraged to begin asking families to donate organs.<sup>3,4</sup> And 2 decades have passed since organ procurement programs were initiated in Augusta and Atlanta. These two programs, now called the Medical College of Georgia Organ Procurement Program and LifeLink of Georgia were given formal and legal approval as the organ procurement programs for Georgia in March, 1988, by the Health Care Financing Administration (HCFA).<sup>5</sup>

Successful heart and liver transplantation was greatly enhanced 5 years ago with the advent of the new immunosuppressant, cyclosporine.<sup>6</sup> To illustrate this point, there have been no deaths within the first post-operative month out of the first 106 heart transplants performed in Atlanta by Murphy and his associates.<sup>7</sup> The liver transplant team at

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**In Georgia, the northwest service area was formally awarded to LifeLink of Georgia (404-872-1782 or 800-544-6667) and the southeast service area to the Medical College of Georgia Organ Procurement Program (404-721-3893 or 800-222-6005).**

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Emory University has performed 44 liver transplants. There have been four persons in Georgia to receive combined heart-lung transplants, and one California man with such has resumed construction work and scuba diving.<sup>8</sup> Heart recipients can expect 80% function for 1 year and 78% for 5 years; liver recipients can expect 70% function at 1 and 68% function at 5 years.<sup>6</sup> Persons await-

ing such transplants, however, are often critically ill; many die during the waiting interval. Of the 20,000 to 30,000 potential organ donors each year, only 4,000 to 5,000 become *actual* donors.

In response to the lower cost of successful renal transplantation in comparison to chronic dialysis and in recognition of the shortage of donor organs, the U.S. Congress in 1976 directed the Centers for Disease Control to study and encourage organ procurement; seed money for additional personnel was allocated to procurement programs in Kansas City, Atlanta, and Augusta. Hospital audits revealed that there were many more potential donors than had been thought.<sup>9</sup> Organ procurement programs and transplantation programs have expanded greatly over the decade since that pilot study, but donor utilization remains woefully low.<sup>10,11</sup>

Clearly, for a potential donor to become an actual donor, the attending physician or his/her designee must request permission for donation from the potential donor's next-of-kin. This is the most diffi-

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cult step in the entire procurement process, but without the support of the physician, donation is very unlikely to occur. To make certain physicians at a symposium in Philadelphia realized how much he wanted to find a liver donor for his child, the child's father stood on the stage and pleaded with them directly. A donor was found, and the transplant was successfully accomplished at the University of Minnesota. In another child's behalf, President Reagan spoke on television. Less dramatic stories are told daily by the news media. As a consequence, there are now state and national regulations requiring hospitals to identify potential donors and offer their families the option of donation. Organ procurement programs regularly strive to increase public awareness of the need for organ donation. There remains, however, a chronic shortage of donor organs. In the United States there are about 16,000 persons waiting for kidneys or for other organs. In 1984, a national task force,<sup>12</sup> chaired by transplant surgeon Olga Jonasson, M.D., was appointed by the U.S. Congress. It emphasized that the attending physician too frequently did not ask the family to donate organs.

### **The Dilemma of the Neurosurgeon**

Although one neurosurgeon<sup>13, 14</sup> editorialized about the neurosurgeon's responsibility for organ procurement, not every neurosurgeon has been comfortable serving as a "double agent."

Dr. Richard G. Nilges,<sup>4</sup> as he approached retirement, described his years as a neurosurgeon. He had worked hard and learned to persevere despite his inability to save every patient with brain injury. Dr. Nilges wrote that he, "had no qualms." But in 1968, a definition of brain death was promulgated by an *ad hoc* committee at Harvard University chaired by Henry K. Beecher, M.D., Chief of Anesthesiology at Massachusetts General Hospital.<sup>3, 14</sup> The criteria were designed to permit cessation of ven-

tilator support of brain dead persons, but were also helpful to those transplant surgeons seeking transplantable organs from "heart-beating cadavers."<sup>15</sup>

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## **UNOS is the federally designated national organ procurement and transplantation network responsible for ensuring the equitable distribution of donor organs. . . .**

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Since 1968, Dr. Nilges and many other neurosurgeons have felt pressure — never subtle and not always gentle — to consider the brain dead patient as a potential organ donor. They experienced anxiety because of the potential conflict of interest. The dilemma might not be severe in the case of a person who has just shot himself in the head, although even here the neurosurgeon feels awkward because he is probably meeting the family for the first time. In the case of a 10-year-old girl on whom he operated 3 days ago, but whose brain has continued to swell and deteriorate, the neurosurgeon's commitment is total. His first charge is to help the patient and his second is to prepare the family for the worst and provide them emotional and physical comfort. A distant third charge is to make a decision regarding a request for organ donation. He wants to give the family time to go through the grieving process, but he knows that the sooner he acts, the more viable the organs will still be. He must determine when brain death occurs;<sup>16, 17</sup> and usually a second physician, in a thankless and unrewarding task, must concur.<sup>18</sup>

Now the primary physician must speak to the family again, hoping

that thoughts about organ donation will not aggravate their grief. He may want someone else to ask permission from the family. Some hospitals have a designated person who makes the request — a person who is knowledgeable and caring (e.g., the hospital chaplain). A procurement coordinator will always be willing to participate, but procurement is regional and the coordinator might have to come from some distance. When permission is granted, the coordinator's formal role is initiated. The physician with prior concern regarding cerebral edema will have limited intravenous fluid administration; the procurement team will recommend increased fluids to enhance kidney function. Hours might pass before all of the surgical teams are able to remove the organs and/or tissues.

Hopefully, the family who denies donation will not have remorse and guilt added to their sorrow. The family who permits donation frequently has a positive feeling<sup>19</sup> which helps to lessen their grief.

### **The Procurement Coordinator's Roles**

When organ donation is being considered, the procurement coordinator affiliated with the program with which the hospital works should be contacted. Often the initial contact should be made before consent for donation is requested, in order to resolve any uncertainty about suitability for donation (Table 1). The designated service areas for the Medical College of Georgia Organ Procurement Program and LifeLink of Georgia are illustrated in Figure 1; LifeLink personnel may be reached at (404)872-1782 or (800)544-6667; the MCG Program's numbers are (404)721-3893 or (800)222-6005.

The coordinator is a paramedical specialist who combines the skills of a psychologist, administrator, and critical care nurse.<sup>15</sup> His or her first role is to educate physicians, nurses, hospital personnel, and the public.<sup>15</sup> The coordinator makes speeches, conducts seminars, and visits hospitals for educational and



# Medical College of Georgia

## Organ Procurement Program

**Potential Donor Referral:**  
(24 hour numbers)

**404-721-3893 - in Augusta area**

**912-234-2213 - in Savannah area**

**912-333-5348 - in Valdosta Area**

**912-228-2000 - in Thomasville Area**

**1-800-222-6005 - Toll Free (if outside the above areas)**

**ORGAN & TISSUE DONOR CRITERIA CHART:**

	KIDNEY	HEART	HEART/ LUNG	LUNG	LIVER	PANCREAS	BONE	SKIN	EYE
Age	6 mos-65	0-45	2-35	1-50	0-50	1-60	18-60	14-75	no limits
Cardiac Arrest resuscitated	Prob. OK	No	No	Possibly	Prob. OK	Prob. OK	Heart beating cadaver not mandatory	Heart beating cadaver not mandatory	Heart beating cadaver not mandatory
Chest/Abd. trauma	Important	Extremely important	Extremely important	Extremely important	Extremely important	Important	Little importance	Not important	Not important
No active Infections	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
No previous disease of organs	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
No presence or history of communicable disease	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
Hypotension	Sensitive	Very Sensitive	Very Sensitive	Very Sensitive	Sensitive	Sensitive	N/A	N/A	N/A
Vasopressor, i.e. Dopamine Sensitive	Yes	Very	Very	N/A	Very	Yes	N/A	N/A	N/A
Weight Important	No	Yes	Yes	Yes	Yes	No	No	> 100 lbs.	N/A
Body Build Important	No	Yes	Yes	Yes	Yes	No	No	No	No
Blood type	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	No	Occasionally
Additional physician consults required	Usually not	Yes	Yes	Yes	Possibly	Usually not	No	No	No
Additional lab needed	Yes Kidney specific	Yes Heart specific	Yes Heart/lung specific	Yes Lung specific	Yes Liver specific	Yes Pancreas specific	No	No	No
Time needed to set up additional teams	Usually Not	Yes	Yes	Yes	Yes	Yes	Possibly	Possibly	Usually Not

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coordinating sessions. The coordinator has another role, that of transplant surgeons' associate. When there is a donor, he or she confirms the donor's suitability, may assist in the management of the donor, and arranges appropriate placement of the donor organs.<sup>20</sup> Surgical procurement teams from the local hospital or transplant program and teams from the heart and/or liver transplant programs jointly perform the donor operation.<sup>21</sup> The coordinator assists with surgical and administrative procedures.

Organs are allocated by a point system devised by Dr. Thomas Starzl<sup>22</sup> of Pittsburgh, Pennsylvania, and modified by the United Network for Organ Sharing (UNOS).<sup>23</sup> (UNOS is the federally designated national organ procurement and transplantation network responsible for ensuring the equitable distribution of donor organs as spelled out in its by-laws.) Factors considered include urgency, time on waiting list, distance involved, and histocompatibility match.<sup>6</sup> Depending on the circumstances, organs may be used for recipients in the local area or may be shared between transplant programs.<sup>23</sup>

Although organ wastage is very low, there remain some difficulties with the current sharing systems. The computerized waiting lists are not always current, and phone contact with several transplant centers is often required for successful placement of extrarenal organs. Unfortunately, some hearts and lungs cannot be used because recipients of suitable size and blood type are not available.<sup>24</sup>

### Recent Legislation

On July 1, 1987, "required request" legislation, passed the previous year by the Georgia General Assembly, went into effect.<sup>25</sup> Similar legislation has been adopted by 42 other states and the District of Columbia, and federal regulations mandate similar programs nationwide.<sup>26,27</sup> This law and its regulations were designed to increase the number of donors and make it eas-

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## Without the support of the physician, organ donation is very unlikely to occur.

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ier for the physician to discuss organ or tissue donation with the families of potential donors. For every hospitalized patient who is about to die or has died, and whose organs or tissues are suitable (Table 1), someone must approach the family for permission for donation. Procurement coordinators are available for phone or on-site consultation to assist in determining whether the potential donor is medically suitable. Obviously, medical suitability should be ascertained prior to approaching the family for permission. When a medically suitable donor is identified, it is the responsibility of the physician or a designated hospital representative to approach the family and offer them the option of donation. The decision made by the family must be noted in the patient's record, as well as in the Anatomical Gift Log. The Joint Commission on the Accreditation of Health Care Organizations (JCAHO)<sup>28</sup> has passed guidelines requiring hospitals to have organ and tissue donor policies in effect. The Sixth Omnibus Reconciliation Act<sup>29</sup> of 1986 also requires that hospitals have such policies in order to receive Medicare and Medicaid reimbursements.

Each hospital in Georgia has been required by HCFA<sup>29</sup> to affiliate with one or the other organ procurement programs; for practical reasons, most have contracted with and will refer donors to the program in their service area (Figure 1). The northwest service area was formally awarded to LifeLink of Georgia (previously called the Atlanta [then Georgia] Regional Organ Procurement Program) by HCFA<sup>5</sup> in March, 1988, and the southeast service area to the Medical College of Georgia Organ Procurement Program.<sup>29</sup> Each procurement program is, and must

be, a member of UNOS.<sup>30</sup> The American Society of Transplant Surgeons will publish soon its guidelines and recommendations.<sup>31</sup>

All costs, from the time the patient is referred as a potential donor (including fees from a cardiologist or other consultant), whether or not the donation is ever consummated, are paid by the procurement program. The program is reimbursed by a system which places an "acquisition cost" for any organ used onto the *recipient's* medical bill. This bill will be paid by a third party, a commercial insurance company or Medicare.<sup>15</sup> Medicare will pay only if the organs and tissues are transplanted by hospitals that meet its requirements. Medicare pays for most kidney transplants and for some liver and heart transplants under very specific circumstances. The sale or purchase of organs or tissues is prohibited by federal<sup>12</sup> as well as state legislation. Procurement programs, whether hospital-based or independent, are non-profit organizations.

These expanded procurement activities have been effective.<sup>33</sup> In the past 6 months, there have been multiple organ and tissue donors (heart, liver, kidneys, eyes, bone, and skin) in cities in Georgia including Fitzgerald, Thomasville, Brunswick, and Valdosta. There have been many more donations of tissues — eyes,<sup>34,35</sup> skin,<sup>36</sup> bone marrow, bones, joints, fascia, dura, pericardium, and heart valves<sup>37</sup> —

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**The physician with prior concern regarding cerebral edema will have limited intravenous fluid administration; the procurement team will recommend increased fluids to enhance kidney function.**

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**When a medically suitable donor is identified, it is the responsibility of the physician or a designated hospital representative to approach the family and offer them the option of donation.**

than in previous years. As transplants become increasingly successful, the donor's family should become even more gratified.

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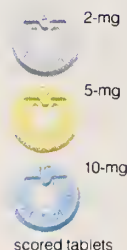
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# Health Care in Juvenile Justice Facilities in Georgia

Bethanne Jenks, M.D., Victor Polizos, M.D., Edward Gottlieb, M.D.

## Introduction

**T**HE AMERICAN MEDICAL ASSOCIATION began to establish standards for health care in juvenile and adult correctional facilities in 1972. Private physicians in Georgia were involved in drafting these initial guidelines. In the past 15 years, however, there has been minimal interaction between the private and public sectors in planning health care in juvenile justice facilities.

In 1987, there were 21 short-term, regional youth detention centers in Georgia (20 are state-operated; one is operated by Fulton County and is partially state subsidized). There are four long-term centers, Youth Development Centers, for youths requiring institutionalization. All 24 state centers are under the Division of Youth Services (DYS) of the Department of Human Resources. During FY87, 25,600 youths in Georgia aged 7 to 16 years were involved with court services. Of these, 12,224 were held in detention for a period of weeks in the Regional Youth Development Centers (RYDCs). Only 1,792 required long-term institutional placement in the Youth Development Centers (YDCs). Georgia has made steady progress over the past 10 years in de-institutionalizing over half the committed youth

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**In 1987, a group of pediatricians, representing the Committee on Adolescents of the Georgia Chapter, American Academy of Pediatrics, approached the Division of Youth Services to inquire about advocacy needs for children in detention.**

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to "alternative placements" such as group homes and community treatment centers.

The 20 state-operated juvenile detention centers are administered in eight regions. Each RYDC serves a specific geographic area of the state and provides supervision while the youth awaits disposition of his/her juvenile court case. There is not an exact correlation between court circuits, RYDC catchment areas, and

county health departments. Relationships between juvenile centers and physician-providers, health departments and local hospitals are diverse, varying substantially across the state. There is at the present time no statewide medical director or system-wide coordination of health care for the Division of Youth Services.

## Survey of Needs

In 1987, a group of pediatricians, representing the Committee on Adolescents of the Georgia Chapter, American Academy of Pediatrics, approached the Division of Youth Services to inquire about advocacy needs for children in detention. The concern was timely, because DYS was recognizing that medical care was a major barrier in its effort to have Georgia facilities meet accreditation standards of the American Correctional Association (ACA).

## Methods

A questionnaire, designed by the American Academy of Pediatrics, was circulated to directors of the 25 facilities. The purpose was to determine the level of compliance

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Drs. Jenks, Polizos, and Gottlieb practice pediatrics. Send reprint requests to Dr. Jenks at 878 Artwood Rd., Atlanta, GA 30307.

TABLE 1 — Levels of On-Site Medical Staffing in Georgia's Juvenile Justice Facilities

Facility	Total Served		Average '87 Daily Census	Sick Call Days/Week	Med. Staff Hrs/Week
	1986	1987			
RYDCs:					
Albany	522	537	26	1	3
Athens	377	393	21	1	2
Augusta	976	901	19	1	1
Blakely	308	281	20	0*	0
Claxton†	—	193	21	1	3-4
Clayton	562	608	26	1	2-3
Columbus	712	687	25	1	2
Dalton	679	584	26	1	1
DeKalb†	—	488	40	2	
Eastman	451	478	19	2	2
Gainesville	741	693	25	1	2
Griffin	592	662	26	1	—
Lawrenceville	801	875	30	1	4
Macon	794	795	29	2	6
Marietta	1211	1232	42	1	2
Rome	717	671	28	1	—
Sandersville	400	368	20	1	2
Savannah	1595	1570	41	1-2	3½
Thomasville†	—	26	9†	0*	0
Waycross	653	670	25	every other week*	—
Fulton‡	2000 +			3-4	9-10

\* Not in compliance with ACA minimum standards

† Claxton, Thomasville, and DeKalb opened in 1987

‡ Fulton is a county-operated facility

with ACA standards and to identify common problem areas among the centers. An additional set of questions focused on minimal standards for medical screening procedures, financial planning for medical care, and local priorities for equipment and services.

The response was brisk, with 100% reply within 1 month, due to endorsement by leading DYS administrators. In examining the data, however, it became evident that there had been no physician involvement in answering the questionnaire. It had been completed by 21 lay administrators and three nurses. Since one key element in meeting accreditation standards is accountability and responsibility of a physician, a supplemental poll of the 25 physicians who work in the juvenile facilities was then conducted.

### Results

ACA standards stipulate that a youth should have a complete

health appraisal (including review of past medical records, physical examination, and laboratory studies) if he or she remains longer than 7 days; a mental health appraisal is required within 30 days. In addition, sick call for non-emergencies should be held at least once a week for facilities holding less than 50 residents, at least twice a week for those with 50-200 census. The data for on-site presence of medical staff performing initial health appraisal and sick call (updated to 1987) are presented in Table 1.

### Discussion

Overall, the survey revealed that the Division of Youth Services has an inadequate, fragmented system of medical care in its 24 facilities. Beyond the baseline of sick call, the facilities' staff have frequent difficulty in having medically untrained workers define which situations are emergencies. Inappropriate use of hospital emergency rooms occurs

often, because of inadequate availability of on-site medical staff and liability concerns of administrators. These off-site trips incur such hidden costs as staff time for personnel to transport and accompany the child, time which takes them from other supervisory and counseling duties. These trips sometimes involve overtime due to long waits at the emergency room. Moreover, there is always the security risk of runaways in these instances.

Medical care for female youths exemplifies the problem of non-standardized screening in the Georgia system. Currently, only syphilis and tuberculin testing are offered in the RYDCs with any uniformity. Gonorrhea and pregnancy tests were only reported as routine at seven centers. Several of the physicians reported feeling unprepared in terms of available time and equipment, and at times uncomfortable, in doing adequate pelvic examinations in this high-risk population.



The lack of financial resources is critical. There is no standard allotment for medical expenses in the RYDCs. (In contrast, adult correction allots 10% of its total prison budget for medical care, which averages \$1600 per inmate annually.) Several other states currently budget in the \$1500-2000 range for juveniles. In contrast to an older population, a juvenile population is more active, has a greater turnover, and is susceptible to more preventable medical conditions. Most RYDCs have funds to contract with private physicians for basic physical examinations and sick call, however, any hospitalization (e.g., broken femur, appendicitis, tubal pregnancy, diabetic acidosis) is an unplanned expense which can create chaos in the RYDC's operating budget. Money for prescriptions and emergency room visits comes out of the general operating account. Policy requires parents to pay for non-committed youth, and DYS attempts to have parents pay for emergency and elective medical care for committed youth. The survey indicated, however, an actual collection rate of less than 5% in all but three centers. Medical specialists who provide consulting services often do not bill, some are not paid, and many assume this work is a charity. It was impossible to get retroactive data on quarterly medical expenses. This lack of consistent recordkeeping renders it difficult to prospectively plan a health budget.

Medical personnel involved with Youth Services have a significant turnover and varying morale. The level of involvement ranges from enthusiastic to perfunctory. A core few are dedicated, competent physicians and staff, willing to make a "house call" to the RYDC in a spirit of community service, supervising and communicating effectively with nurses and other staff, despite obvious restrictions on time and funds. The majority, however, are part-time contractors who can spare minimal investment in time or energy and who see little hope of giving comprehensive care.

Statewide, the 20 RYDCs are expected to provide 24-hour care for an average daily census of 508 delinquent youths with no on-site medical service capability. Because of the above constraints, some youths who become ill or injured are simply discharged from the facility to the care of their parents or other guardian. ACA standards specify that health care services for institutions must be under the guidance of a single responsible physician. Over 50% of the RYDCs do have a physician designated and paid for regular visits, yet the majority do not yet have anyone responsible for arranging 24-hour coverage. The AAP survey found that 18 of the 21 detention facilities had sick call at least once a week. On all other days, the initial assessment, screening, and medical referral for illness or injury to youths are currently being done by medically untrained staff.

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**A survey designed by the American Academy of Pediatrics and conducted in Georgia found that current level of health service provided to youths in juvenile justice facilities is not uniform and is inadequate to meet American Correctional Association standards.**

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The interface of medical and legal rights was also often obscure at these facilities. Concepts of "confidentiality" and "right to refuse" non-emergency care were not generally understood by line-staff at the

juvenile centers and were not consistently applied. At 11 centers, medical records were not kept separately.

In summary, the AAP survey found that current level of health service provided is not uniform and is inadequate to meet American Correctional Association standards.

### **Further Issues**

While the pediatricians were asked to focus on physical health, mental health has been the critical management problem addressed by previous audits, task forces, and ACA consultation in 1981, 1983, 1984 and 1985. About one in seven detained youths have special needs (mental retardation or psychoses) and do not respond either to a traditional correctional setting or to traditional treatment programs in the private sector. Special programs designed for these juveniles are a priority for the Division of Youth Services.

The four long-term Youth Development Centers have bed capacities from 100 to 300 youths each. The need to plan and fund the necessary staff to therapeutically handle the mental health needs of committed youth is paramount.

### **Recommendations**

Based on the survey conducted by the AAP, on task force reports by medical and justice system professionals, and on in-house examination by Division administrators, the following recommendations are proposed:

1. Create a position of *Medical Director* within the Division of Youth Services of Department of Human Resources. A Medical Director with background in adolescent medicine is needed to supervise quality of health care delivery, planning, and training. A central authority could coordinate achievement of adequate standards of care.



2. Formalize cooperative agreements between Youth Services and *Public Health* to improve health care delivery in the 24 facilities. Interagency agreements between DYS and Department of Public Health could clarify the roles and responsibilities of each to better meet the needs of high risk youths. Subsequently, local arrangements between DYS regional centers and county health departments should encourage maximal overlap of resources.

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**Financing is needed to raise juvenile health care to the level of staffing provided to adult offenders.**

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3. Designate a *responsible physician* for each of the 20 RYDCs and for each of the four YDCs. The authority and accountability of the physician-in-charge should be created contractually and compensated accordingly, with due awareness of liability compensation. Each of the 24 physicians would report to the Medical Director. The regional physician in charge would implement medical policies and procedures designed and standardized with the Medical Director, would directly supervise and coordinate ancillary medical staff to provide 24-hour access to medical care, would coordinate with facility administrators and counselors in-service basic medical training of direct care staff, supervise needs for equipment and supplies, and submit quarterly reports and annual statistical summaries.

4. Part-time *on-site medical personnel* should be hired for all 20 RYDCs. These could be nurse-practitioners or physicians assistants where appropriate. This would reduce the facilities' dependence on local emergency rooms and allow monitoring of juveniles currently on medications and other follow up for chronic conditions.

#### **Conclusion**

The first systematic survey of physical health services in Georgia's juvenile centers was conducted in 1987. The health delivery system suffers from lack of coordination in both staffing and level of care, has disorganized screening and over-utilization of off-site services for non-emergency health needs, lacks health training for facility staff, and has marginal recordkeeping.

Recommendations are to fund a Medical Director, accountable physicians, on site paraprofessional medical staff, and to coordinate existing resources with public health.

With the traditional budget cycle taking 18-24 months, system-wide changes could not normally be made until FY90 or later. With the Governor's Commission on Children and Youth targeting juveniles as a political priority for this term, however, we are encouraged to seek initiatives to upgrade medical services in the Division as soon as possible. These services should at the very least be comparable to those provided by the state for adult inmates.

Lack of consistent policy and resources for medical care to juvenile offenders ultimately affects physicians and other health professionals from all primary care and consulting specialties. Continuing communication and support is needed from the private medical community.

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**Recommendations to improve the health care of juveniles in detention centers include funding a Medical Director, accountable physicians, on-sight paraprofessional medical staff, and coordinating existing resources with public health.**

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#### **Acknowledgements**

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- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%, and, rarely, thrombocytopenia.

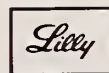
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## Endobronchial Brachytherapy

Thomas W. Phillips, M.D.

**L**UNG CANCER is the most common form of cancer diagnosed in the United States and also the major cause of cancer death. In 1987, there were approximately 150,000 new cases of and 136,000 deaths from lung cancer. Two-thirds of the new cases and deaths will occur among males. Incidence has increased about 240 percent over the past 5 years, with a similar increase in mortality. Five-year relative survival rates are only 13 percent, although if detected while the tumor is still localized to the lung, the 5-year relative survival rate increases to 35 percent. Recently, however, there has been a decrease in incidence among white males and essentially no change in mortality. These positive signs are associated with a reduction in cigarette smoking since 1965.<sup>1</sup>

Patients with large cell carcinoma of the lung are often found to be inoperable. Inoperability is due to patient refusal, insufficient pulmonary function, concomitant severe disease(s), locally advanced carcinoma, or distal metastases. The response rate for non-oat cell carcinomas to chemotherapy is very low, so most of these patients receive radiation therapy as their primary treatment. Radiation therapy for lung cancer is often quite successful in controlling the local disease (65%

**‘Presently available in the Atlanta area are second generation devices to deliver endobronchial radiation. They are high intensity Iridium-192 sources attached to the end of a flexible steel cable of 0.6 mm diameter.’**

treated with at least 6000 cGy). But 75-80% of these patients develop distal metastases. Perez, et al<sup>2</sup> have shown that local control of lung cancer is related to the dose of radiation given.

In an effort to deliver higher doses of radiation to lung cancers, several institutions have used intracavitary radiation with radiation sources of Cobalt-60,<sup>3</sup> Radon-222, Iodine-125, and

Iridium-192.<sup>4,5</sup> Schray, et al<sup>6</sup> have used Iridium-192 in combination with laser therapy to relieve bronchial obstruction.

**P**resently available in the Atlanta area are second generation devices to deliver endobronchial radiation. These devices have high intensity Iridium-192 sources attached to the end of a flexible steel cable of 0.6 mm diameter. This Iridium source is mechanically passed into a number 5 Fr. catheter in stepped increments to deliver a prescribed dose within the bronchus. Control of the stepping device is by an IBM computer system which is programmed for each application according to the specific needs of each patient. With this technique, much higher doses of radiation can be given to small controlled volumes of tissue.

To date, 60 procedures have been performed at Crawford Long Hospital. There have been no acute complications associated with the procedure. One patient was hospitalized the day after the procedure because of shortness of breath. No direct association with the procedure could be found. The procedure is performed on an outpatient basis and requires sedation for the bronchoscopic examination only.

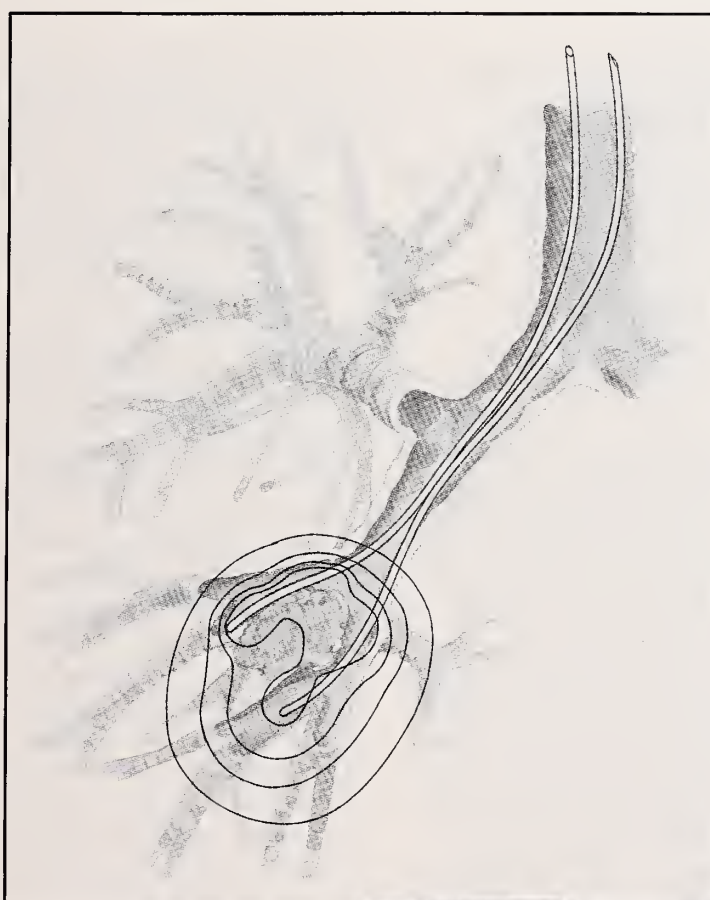
There has been marked regression of endobronchial

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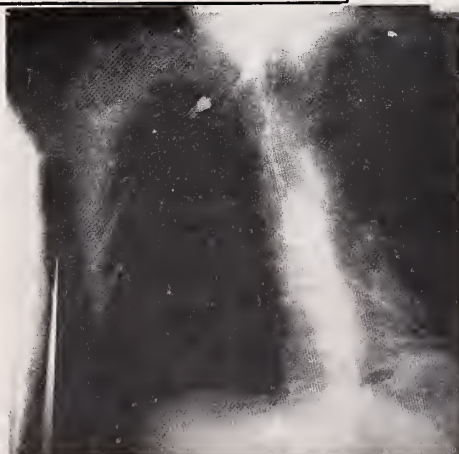
This paper was sponsored by the Georgia Division of the American Cancer Society. Those wishing to contribute papers to the CANCER Section should send them to Dr. Phillips, CANCER Section Editor, at the above address.





## DOSE DISTRIBUTION

*A typical example of a lung implant using two flexible catheters of 1.9 mm diameter. The applicators are inserted through the bronchoscope. Once the applicators have been positioned radiographic markers are placed and A.P. and lateral radiographs are taken from which the position of the applicators can be determined and the corresponding isodose distribution calculated with the Nucletron Planning System.*



tumor in all patients. External radiation is given concomitantly. Laser therapy preceded the endobronchial treatment in one patient. Follow-up is too short to evaluate long term complications and/or benefits.

## Summary

Endobronchial brachytherapy is a new outpatient technique available for selected lung cancer patients. It allows the delivery of higher doses of radiation which may result in improved local control. It also is very useful for palliation of airway obstruction and bleeding.

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## Follow Up on Emory University v. Houston

Robert N. Berg

**I**N THE JULY, 1988, ISSUE of the *Journal*, we discussed the case of *Emory University v. Houston*, which had been recently decided by the Georgia Court of Appeals.<sup>1</sup> This case involved an alleged cover-up of improper eye surgery by a physician. Following review by three different peer review committees, information was leaked to the press, indicating that the committees had concluded the physician had not engaged in malpractice. Based upon this publication of the results of the committee proceedings, as well as certain other arguments, the plaintiff had contended that the statutory confidentiality accorded to peer review proceedings and records<sup>2</sup> had been waived, and that he was entitled to discover the substance of the committee's peer review proceedings.

The Georgia Court of Appeals had agreed, holding that the correct interpretation of the Peer Review Statute allowed for a waiver of confidentiality, just as other types of confidential communications (e.g., husband/wife, accountant/client, etc.) may be waived. The Court of Appeals was also persuaded by the fact that the Peer Review Statute itself provided no sanction for breach of the privilege granted to peer review committee records and proceedings, thus indicating to the Court that the intent of the

### **‘Georgia Supreme Court imposes “absolute embargo” on the discovery and use of peer review proceedings and records.’**

Peer Review Statute was not to prohibit, in all circumstances, the disclosure of confidential peer review records and proceedings.

In the July Legal Section, we pointed out that the Court of Appeals' decision had been appealed to the Georgia Supreme Court and that, if the Supreme Court affirmed the lower court's decision, the expansive nature of the protection provided by the Peer Review Statute would be substantially limited, should patients, physicians, or others seek successfully to obtain information generated or produced by peer review committees, on the basis of claims that the statutory privilege with respect to peer review proceedings and records had been waived. We also pointed out

that, should these types of waiver claims be successful, the entire peer review process might be jeopardized, as physicians became less likely to exercise the degree of candor necessary for the effective functioning of physician peer review committees.

### **Supreme Court Imposes “Absolute Embargo”**

Perhaps recognizing this possibility, the Georgia Supreme Court reversed the lower court's decision, holding that the protection granted to peer review records and proceedings under the Peer Review Statute could *not* be waived.<sup>3</sup> As stated by the Court, “the [Georgia] General Assembly has placed an *absolute embargo* upon the discovery and use of all proceedings, records, findings and recommendations of peer review groups and medical review committees in civil litigation.” (Emphasis Supplied.)<sup>4</sup>

Thus, the Supreme Court specifically held that, even if the results of the pertinent committee proceedings had been leaked to the Atlanta papers, this action could under no circumstances result in the waiver of the protection afforded to those proceedings under the Peer Review Statute. In particular, the Court noted that “(a) person who has nothing to waive can waive nothing. Hence, prior newspaper

This article was prepared at the request of the *Journal*. Mr. Berg is a partner in the law firm of Vincent, Chorey, Taylor & Feil, Suite 1700, The Lenox Building, 3399 Peachtree Rd., Atlanta, GA 30326. Send reprint requests to Mr. Berg.



reports of peer review information cannot alter the prohibition on discovery of peer review information in civil litigation."<sup>5</sup>

The Court similarly noted that the source of the information leaked to the press also was irrelevant, in terms of determining whether or not the statutory privilege for peer review proceedings and records could be waived. Thus, regardless of who provided information to the press, or how the press got that information, the information — if constituting the proceedings or records of peer review committees — simply cannot be discovered in a civil lawsuit.<sup>6</sup>

### "Candor" v. "Cover-Up"

The Supreme Court's decision was not without dissent. Indeed, one of the Justices severely criticized the majority's decision on the grounds that "(t)he 'absolute embargo' construction allows the worst kind of abuse (i.e., fraud, deceit and conspiracy). The construction enhances the potential for a decrease in the quality of health care rather than fostering quality health care. . . . We cannot allow health care providers to be unaccountable."<sup>7</sup>

To this dissenting Justice, the majority's construction of the Peer Review Statute, totally precluding discovery of the proceedings and records of peer review

committees, served to allow physicians to engage in the worst kinds of negligence or misconduct, by providing them with the ability to keep these actions from being discovered. Thus, the decision served, in this Justice's view, to raise more questions than it answered:

*The [Georgia] legislature never intended for the [peer review] statutes to be used to prevent the truth. The goal of the legislature was to foster the delivery of quality health care services. There are some important questions which must be addressed. Is the delivery of quality health care fostered by silencing doctors who wish to testify regarding statute abuses? Is the delivery of quality health care fostered by allowing health care providers absolute power over discovery in the face of alleged abuse? Is the delivery of quality health care fostered by granting health care providers with the power to be accountable only to themselves in the face of alleged abuse? Is there any other big business in this state that is afforded the absolute power over discovery? Is there any other big business in this state that is afforded the power to be accountable only to themselves? The answers to the questions indicate that the*

*majority is wrong. The goal of the legislature is to foster "candor" not "cover-up."*<sup>8</sup>

### Conclusion

The decision of the majority of the Supreme Court arguably represents a narrow legalistic view of the Peer Review Statute, albeit one that is clearly in line with that Court's prior interpretations of that Statute.<sup>9</sup> By the same token, the dissenting opinion clearly reflects an acknowledgement of the "bad facts" involved in the case (e.g., allegations that the defendant physician operated on the wrong eye and thereafter spearheaded an effort to cover-up the negligence). It remains to be seen, however, whether the majority Court's opinion will result in the horrible consequences suggested by the dissenting Justice — or whether it will allow efficient, quality peer review to continue to be conducted by hospitals and physicians throughout the State.

### Notes

1. 185 Ga.App. 289, 364 S.E.2d 70 (1987).
2. O.C.G.A. §§31-7-133 and 31-7-143 (together the "Peer Review Statute").
3. *Emory Clinic v. Houston*, \_\_\_\_\_ Ga. \_\_\_\_\_ (July 15, 1988).
4. *Id.*, at \_\_\_\_\_.
5. *Id.*, at \_\_\_\_\_.
6. *Id.*, at \_\_\_\_\_.
7. *Id.*, at \_\_\_\_\_.
8. *Id.*, at \_\_\_\_\_.
9. See, e.g., *Eubanks v. Ferrier*, 245 Ga. 763, 267 S.E.2d 230 (1980); *Hollowell v. Jove*, 247 Ga. 578, 279 S.E.2d 430 (1981).



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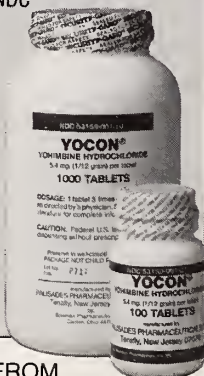
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#### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

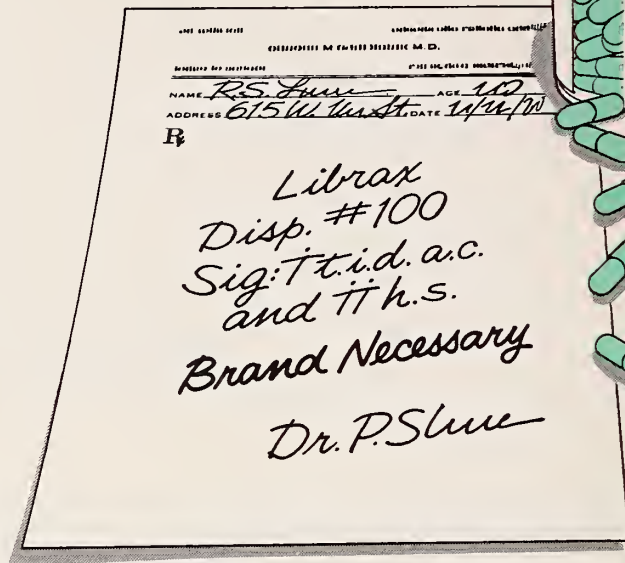
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Specify Adjunctive.

# LIBRAX®



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide.

Please consult complete prescribing information, a summary of which follows:

- \* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:  
 "Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.  
 Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.  
**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

**Use in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur. Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary.

Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

**Drug Abuse and Dependence:** Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. After extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.



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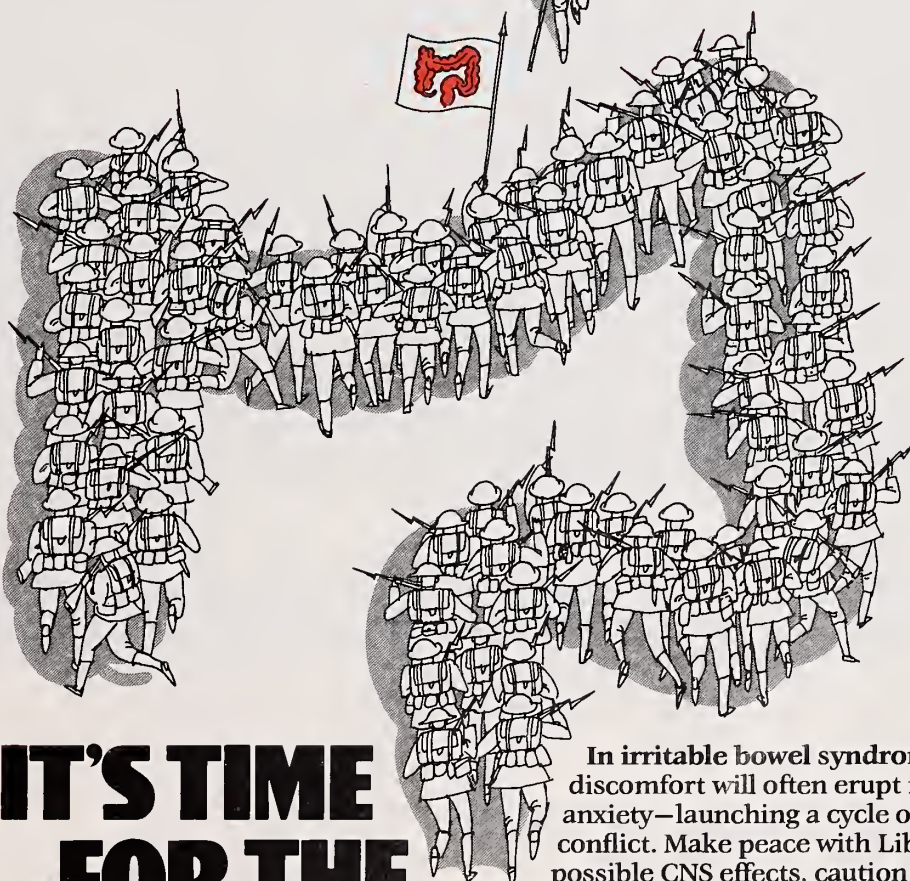
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When it's brain versus bowel,



# IT'S TIME FOR THE PEACEMAKER.

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\*Librax has been evaluated as possibly effective as adjunctive therapy in the treatment of peptic ulcer and IBS.

Specify Adjunctive

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1988 MAG Scientific Assembly

November 11-13, 1988

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City/State \_\_\_\_\_ Zip Code \_\_\_\_\_

**IMPORTANT! PLEASE INDICATE THE PROGRAM FOR WHICH YOU WISH TO REGISTER (check one)**

- ☐ Allergy & Immunology
- ☐ Chest Disease
- ☐ Neurology
- ☐ Neurosurgery
- ☐ Ophthalmology
- ☐ Otolaryngology/Head & Neck Surgery
- ☐ Pathology
- ☐ Plastic Surgery
- ☐ Psychiatry

**REGISTRATION FEES (Please Check One)**

**PHYSICIAN**

- ☐ \$80 MAG Member ☐ \$125 Non-Member

**RESIDENT PHYSICIAN**

- ☐ No Fee Member ☐ \$15 Non-Member

**STUDENT**

- ☐ No Fee Member ☐ \$10 Non-Member

**OTHER HEALTH PROFESSIONAL**

- ☐ \$40

**PROGRAM CHAIRMAN OR SPEAKER**

- ☐ No Fee

DETACH THE TOP PORTION OF THIS FORM  
AND MAIL TO:

**MAG SCIENTIFIC ASSEMBLY**  
938 Peachtree Street, NE  
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CHECKS SHOULD BE MADE PAYABLE TO  
THE MEDICAL ASSOCIATION OF GEORGIA.  
Payment must accompany this form. No  
refunds may be given after November 9.

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Departure Date \_\_\_\_\_ Time \_\_\_\_\_

Please mail to: RITZ-CARLTON BUCKHEAD HOTEL, 3434 Peachtree Rd., N.E., Atlanta, GA 30326

Group And Meeting Dates

Medical Association of Georgia  
Scientific Assembly

November 10-14, 1988

Reservations must be received by October 24, 1988.

**Rates**

If rate requested is not available, nearest rate will be reserved.

Single - 1 Person \$93.00

Double - 2 Persons - 1 Bed \$93.00

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## RITZ-CARLTON BUCKHEAD HOTEL

NOVEMBER 11-13  
ATLANTA

### PRELIMINARY PROGRAM

## GENERAL INFORMATION

### ABOUT THE MEETING

This year's MAG Scientific Assembly features clinical sessions in these specialties: allergy and immunology, chest disease, neurology, neurosurgery, ophthalmology, otolaryngology, pathology, plastic surgery and psychiatry. Each of these programs has been arranged by the respective specialty society, with topics and speakers likely to be of most interest and pertinence to its members.

### THREE "BONUS" PROGRAMS: INFORMED CONSENT, MEDICARE UPDATE, AND PHYSICIAN ANTI-TRUST

Also scheduled during the Scientific Assembly, free for all registrants, are three short seminars on topics of keen interest to physicians: Georgia's new informed consent law, the latest Medicare update, and the latest developments in medical anti-trust action. Each of these updates, about 45 minutes long, will be scheduled on Friday and Saturday at the Ritz Carlton, at convenient times for our Scientific Assembly attendees.

More information on the Informed Consent, Medicare, and Anti-trust updates will be available at our registration desk for the meeting.

### REGISTRATION INFORMATION

Registration for the MAG Scientific Assembly allows a physician to attend any and all CME programs held during the weekend. To register for these scientific meetings, please complete the registration form inserted in this *Journal*, detach it from the hotel reservation form, and mail it with your registration fee to the MAG office.

### REGISTRATION FEE

	MAG Member	Non- Member
Physician	\$80	\$125
Resident Physician	No fee	\$ 15
Medical Student	No fee	\$ 10
Other Health Professional	\$40	
Program Chairmen or Speakers:	No fee	

If you need more registration forms, call the MAG office in Atlanta (876-7535 or toll free in Georgia: 800/282-0224). We will

gladly mail you as many as you need. Early registration is advised. General registration desks will also be open at the Scientific Assembly Friday 8:00 AM-4:00 PM; Saturday 8:00 AM-4:00 PM; and Sunday 8:00 AM-Noon.

### LODGING

If you wish hotel accommodations at the Ritz-Carlton, please complete and detach the bottom portion of the registration form and mail it directly to the Ritz-Carlton Buckhead Hotel. Reservations received by the hotel after October 29 will be met on a space-available basis.

### PROGRAM OBJECTIVES

The specialty society programs of the MAG Scientific Assembly are intended to provide the practicing physician with current clinical information on pertinent topics. Each of the specialty programs has been planned by a Program Chairman from the respective specialty societies, based on the educational needs and interests of his or her colleagues.

## ALLERGY AND IMMUNOLOGY SOCIETY OF GEORGIA

*Program Chairman:*  
*W. Ronald Tipton, M.D., Atlanta*  
Vice President, Allergy &  
Immunology  
Society of Georgia

*Faculty:*  
*James R. Baker, Jr., M.D.*  
Clinical Associate Professor of  
Medicine  
F. Edward Hebert School of  
Medicine  
Uniformed Services University of  
the Health Sciences  
Bethesda, MD

*Stanley J. Szeffler, M.D.*  
Associate Professor of Pediatrics  
and Pharmacology  
University of Colorado School of  
Medicine  
Denver

8:00-8:15

■ Registration

8:15-8:30

■ **Case Report on Common  
Variable Immunodeficiency with  
Natural Killer Defect**

*John Yarbrough, M.D.*  
Fellow, MCG

8:30-8:45

■ **Evidence for Induction of  
Sodium Channel Activity  
Following Activation of Murine  
Mast Cells**

*Lawrence P. McKean, M.D.*  
Fellow, Emory Univ. Sch. of Med.

8:45-9:00

■ **Delayed Reaction to Prick  
Skin Testing**

*Lisa Hutto, M.D.*  
Fellow, MCG

9:00-9:40

■ **Corticosteroids in Allergic  
Diseases**

*Stanley J. Szeffler, M.D.*  
(Sponsored by Rorer)

9:40-10:00

■ **Coffee Break** (Sponsored by  
Greer)

10:00-10:30

■ **HIV-Positive Military  
Personnel**

*James R. Baker, Jr., M.D.*  
(Sponsored by Schering)

10:30-11:00

■ **Theophylline Metabolism**  
*Stanley J. Szeffler, M.D.*

11:00-12:00

■ **Business Meeting**  
Meeting of the Allergy &  
Immunology Society of Georgia

12:15-1:30

■ **Luncheon**  
Allergy & Immunology Society  
Sponsored by Fisons)

We gratefully acknowledge the generosity of Rorer  
Pharmaceuticals and Schering Laboratories for their  
sponsorship of Dr. Szeffler and Dr. Baker. We also wish  
to thank Greer Laboratories for sponsoring the Society's  
coffee break, and Fisons Pharmaceuticals for the  
luncheon.

# CHEST DISEASE

## GEORGIA THORACIC SOCIETY GEORGIA CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS

*Program Chairman:*  
*James W. McCormick, M.D.,*  
Augusta

*Guest Faculty:*  
*Donald E. Craven, M.D.*  
Director of AIDS Public Health  
Activities for the City of Boston &  
Boston City Hospital  
Associate Professor of Medicine  
Boston University School of  
Medicine

*David Curiel, M.D.*  
Senior Staff Investigator  
Pulmonary Branch, National  
Heart, Lung and Blood Institute  
National Institutes of Health  
Bethesda, MD

*Samuel Z. Goldhaber, M.D.*  
Cardiology Division  
Brigham and Women's Hospital  
Assistant Professor of Medicine  
Harvard Medical School  
Boston

*Stephen S. Lefrak, M.D.*  
Director of Medical Intensive Care  
Unit  
Jewish Hospital of St. Louis  
Professor of Medicine  
Washington University School of  
Medicine  
St. Louis

*Herbert Y. Reynolds, M.D.*  
Chairman, Department of  
Medicine  
Professor of Medicine  
Milton S. Hershey Medical Center  
Hershey, PA

*Steven A. Sahn, M.D.*  
Professor of Medicine  
Director, Division of Pulmonary  
and Critical Care Medicine  
Medical University of South  
Carolina  
School of Medicine  
Charleston

**SATURDAY, November 12,  
1988**

9:00-10:00

■ **Approaches to Mechanical  
Ventilation**

*Stephen S. Lefrak, M.D.*



(Supported by a grant from Glaxo Corporation)

10:00-11:00

■ **Host Defense Mechanisms in the Lung**

*Herbert Y. Reynolds, M.D.*  
(Sponsored by Georgia Chapter, American College of Chest Physicians and a grant from Boehringer Ingelheim LTD)

11:00-11:15

■ **Coffee Break**

11:15-12:15

■ **Pathogenetic Mechanisms of Pleural Effusion: Clinical Implications**

*Steven A. Sahn, M.D.*

(Supported by a grant from Schering Laboratories)

12:15-1:30

■ **Lunch**

1:30-2:30

■ **Risk Factors for Nosocomial Pneumonias**

*Donald E. Craven, M.D.*

2:30-3:30

■ **New Therapeutic Strategies in the Management of Emphysema**

*David Curiel, M.D.*  
(Supported by a grant from Cutter Biological)

3:30-3:45

■ **Coffee Break**

3:45-4:45

■ **Advances in Thrombolytic Therapy of Pulmonary Embolism**

*Samuel Z. Goldhaber, M.D.*  
(Supported by a grant from Genentech)

We gratefully acknowledge the sponsorship of guest speakers by the following companies: Boehringer Ingelheim LTD, Dr. Reynolds; Cutter Biological, Dr. Curiel; Genentech, Dr. Goldhaber; Glaxo, Inc., Dr. Lefrak; Schering Laboratories, Dr. Sahn.

## NEUROLOGY

SATURDAY

### GEORGIA NEUROLOGICAL SOCIETY

*Program Chairman:*  
*Mark A. Kozinn, M.D., Atlanta*

9:00-3:00

■ **Epilepsy**

*Billy Joe Wilder, M.D.*  
University of Florida School of Medicine

■ **Dyskinesia**

*Kapil D. Sethi, M.D.*  
Medical College of Georgia School of Medicine

■ **Neurologic Complications of AIDS**

*Robert Janson, M.D.*  
Centers for Disease Control

■ **Behavioral Changes Associated with Temporal Lobe Epilepsy**

*Robert C. Green, M.D.*  
Emory University School of Medicine

■ **PET Scanning and Acute Stroke**

*Bruce Mackay, M.D.*  
Assistant Professor, Department of Neurology  
Emory University School of Medicine

The Society will also sponsor a luncheon for its members.

We gratefully acknowledge the support of CIBA-GEIGY Pharmaceuticals for this program.

## OPHTHALMOLOGY

SATURDAY

### GEORGIA SOCIETY OF OPHTHALMOLOGY

SATURDAY

*Program Chairman:*  
*Paul Sternberg, Jr., M.D., Atlanta*

*Guest Speaker:*

*Jack Holladay, M.D.*  
Associate Professor of Ophthalmology  
Hermann Eye Center  
University of Texas Medical School, Houston

SATURDAY, November 12

Session #1 — William H. Jarrett, II, M.D., Moderator

8:30-8:40

■ **Intraocular Hemorrhage in Hemophilia**

*Brent Norman, M.D.*

8:40-8:50

■ **Vitreotomy in Management of Von Hippel's Angiomatosis**

*William S. Hagler, M.D.*

8:50-9:00

■ **Vitreotomy For Giant Retinal Tear**

*Shelby Wilkes, M.D.*

9:00-9:10

■ **Discussion**

9:10-9:20

■ **Vitreotomy for Trauma Study**

*Paul Sternberg, Jr., M.D.*

9:20-9:30

■ **Macular Holes**

*E. H. Donnelly, M.D.*

9:30-9:40

■ **Scleral Buckling: An Outdated Operation?**

*Travis A. Meredith, M.D.*

9:40-9:50

■ **Discussion**

9:50-10:00

■ **Management of Peripheral Uveitis (Pars Planitis)**

*Thomas M. Aaberg, M.D.*

10:00-10:10

■ **Radiation Retinopathy**

*Frank Bell, M.D.*

10:10-10:20

■ **Collaborative Ocular Melanoma Study**

*William H. Jarrett, II, M.D.*

10:20-10:30

■ **Discussion**

10:30-11:00

■ **Coffee Break**

*Session #2 — Thomas Rowe, M.D., Moderator*

11:00-11:30

■ **Decision-Making in IOL Power Calculations**

*Jack Holladay, M.D.*

11:30-11:40

■ **Posterior Chamber Intraocular Lens Implantation with Posterior Capsule Rupture**

*James Jachimowicz, M.D.*

11:40-11:50

■ **Specular Microscopy — Can It Really Help Me Evaluate My Patient?**

*Philip E. Newman, M.D.*

11:50-12:00

■ **Hyperopia Surgery — Radial Thermal Keratoplasty**

*Robert H. Marmer, M.D.*

12:10-12:20

■ **Penetrating Keratoplasty vs. Epikeratophakia for Keratoconus**

*R. Doyle Stulting, M.D., Ph.D.*

12:20-12:30

■ **Advances in Cornea and Anterior Segment**

*Alan M. Kozarsky, M.D.*

12:30-12:40

■ **New Methods of Preventing, Measuring, and Managing Astigmatism Associated with Penetrating Keratoplasty**

*George O. Waring, III, M.D.*

12:40-12:50

■ **Discussion**

12:50-2:00

■ **Lunch**

*Session #3 — J. Donald Fite, M.D., Moderator*

2:00-2:30

■ **Current Concepts in Glare and Contrast Sensitivity Testing**

*Jack Holladay, M.D.*

2:30-2:40

■ **Discussion**

2:40-2:50

■ **Internal Sclerectomy for Advanced Glaucoma**

*Mary Lynch, M.D.*

2:50-3:00

■ **Clear Cornea Cataract Extraction in Filtered Patients Using 5-FU**

*Thomas S. Harbin, Jr., M.D.*

3:00-3:10

■ **Hydrogen Peroxide: Effects on Anterior Chamber Structures**

*David S. Hull, M.D.*

3:10-3:20

■ **Discussion**

3:20-3:30

■ **Congenital Retinal Dystrophies: A Reappraisal of the Diagnosis**

*Scott Lambert, M.D.*

3:30-3:40

■ **Unusual Causes for Ptosis**

*Zane F. Pollard, M.D.*

3:40-3:50

■ **Problems in the Surgical Management of the Grave's Patient**

*Clinton D. McCord, M.D.*

3:50-4:00

■ **Discussion**

4:00

■ **Adjourn**

## OTOLARYNGOLOGY — HEAD AND NECK SURGERY

### GEORGIA SOCIETY OF OTOLARYNGOLOGY/ HEAD AND NECK SURGERY

#### FRIDAY

*Program Chairmen:*

*Albert E. Clairmont, M.D., Atlanta*  
*William E. Silver, M.D., Atlanta*

*Guest Speaker:*

*Arnold G. Schuring, M.D.*  
Private practice, otologic surgery  
Warren, OH

#### FRIDAY, November 11

9:00-9:15

■ **Welcome and Introduction**

*Albert A. Clairmont, M.D., &*  
*William E. Silver, M.D.*

9:15-9:45

■ **The Anatomical Status Achieved with Closed and Open Techniques of Nasal Tip Rotation**

*William E. Silver, M.D.*

Private practice, facial plastic surgery  
Atlanta

9:45-10:00

■ **Introduction of Speaker**

*William E. Silver, M.D.*

10:00-10:30

■ **Developing an Informed Consent**

*Arnold Schuring, M.D.*

10:30-10:45

■ **Coffee Break**

10:45-11:30

■ **Chronic Sinusitis — Medical, Allergic & Surgical Treatment Including Telescopic Sinus Surgery**

*Hamilton Dixon, M.D.*



Private practice, otolaryngology/  
head & neck surgery  
Rome, GA

11:30-12:30

■ **Sinusitis in Cystic Fibrosis**

*John Per-Lee, M.D.*

Associate Professor of  
Otolaryngology  
Emory University School of  
Medicine  
Atlanta

12:00-2:00

■ **Luncheon**

2:00-2:30

■ **Cochlea Implant**

*Ronald Steenerson, M.D.*  
Private practice, otology  
Atlanta

2:15-2:30

■ **Introduction of Speaker**

2:30-3:30

■ **Staging for Cholesteotoma: A Controversy**

*Arnold Schuring, M.D.*

3:30-4:00

■ **Neck Dissection — Are We Asking the Right Questions?**

*Albert A. Clairmont, M.D.*

Private practice, head & neck  
surgical oncology  
Atlanta

4:00

■ **Adjournment**

## PATHOLOGY

SATURDAY AND SUNDAY

### GEORGIA ASSOCIATION OF PATHOLOGISTS ATLANTA SOCIETY OF PATHOLOGISTS

SATURDAY, November 12

*Program Chairman:*

*Edward E. Hahn, M.D.*, Savannah  
President, Georgia Association of  
Pathologists

8:00-8:30

■ **Registration**

8:30-9:30

■ **New Techniques of Breast Pathology**

*Cynthia Cohen, M.D.*

Director of Surgical Pathology  
Emory University School of  
Medicine  
Atlanta

9:30-10:30

■ **Quality Assurance in the Laboratory**

*David Vroon, M.D.*

Associate Chief of Pathology &  
Laboratory Medicine  
Grady Memorial Hospital  
Atlanta

10:30-10:45

■ **Coffee Break**

10:45-11:45

■ **Business Meeting**

Members of the Georgia  
Association of Pathologists

12:00-1:45

■ **Luncheon and Guest Speaker**

"Perfect Doctors, Important Health  
Care Executives, Friendly  
Politicians and Other Con Artists I  
have known"

*Gordon Johnson, M.D.*

Crystal City, MO

All attendees of the Scientific  
Assembly are invited to hear Dr.  
Johnson's entertaining  
presentation. Call the MAG office  
for reservations.

2:00-5:00

■ **Workshop: Physicians' Office Laboratory: New Challenges and New Opportunities**

*Curtis Bakken, M.D.*

Medical Director, Mayo Medical  
Laboratories  
Mayo Clinic  
Rochester, MN

*Robert Kisabeth, M.D.*

Sr. Associate Consultant to Mayo  
Medical Laboratory  
Mayo Clinic  
Rochester, NM

*Gerald Wollner*

Administrator  
Department of Laboratory  
Medicine and Pathology  
Mayo Clinic  
Rochester, MN

### ATLANTA SOCIETY OF PATHOLOGISTS ANNUAL SLIDE SEMINAR

*Program Chairman:*

*Barbara A. Slade, M.D.*, Atlanta  
President, Atlanta Society of  
Pathologists

*Guest Speaker:*

*Aidan J. Carney, M.D.*

Professor of Pathology, Consultant  
in Surgical Pathology  
Department of Laboratory and  
Medical Pathology  
Mayo Medical School  
Rochester, MN

9:00-1:00

■ **Pathology of Endocrine Diseases**

A coffee break is scheduled  
during Dr. Carney's slide  
presentation, 10:30-11:00 a.m.

Microscopic slide study sets,  
including clinical protocols, have  
been prepared for the cases  
which Dr. Carney will present.  
Sets available for \$40. Requests  
should be submitted to: Barbara  
A. Slade, M.D., Clinical  
Laboratory, Grady Memorial  
Hospital, 80 Butler St., Atlanta, GA  
30335; PH: (404) 589-4800.

## GEORGIA SOCIETY OF PLASTIC SURGEONS

*Program Chairman:*

*W. Jefferson Pendergrast, M.D.,  
Atlanta*

*Faculty:*

*Gordon H. Sasaki, M.D., F.A.C.S.,  
Assistant Professor of Plastic and  
Reconstructive Surgery*

University of Southern California,  
Los Angeles School of Medicine

9:00-1:00

### ■ Refinements in Tissue Expansion

*Gordon H. Sasaki, M.D.*

A coffee break is scheduled for  
11:00-11:15 a.m.

1:00-2:30

### ■ Luncheon and business

### meeting

Georgia Society of Plastic Surgeons

Reservations must be made for the Society luncheon by noon, November 9, by contacting Dr. Pendergrast's office, 993-F Johnson Ferry Rd., Ste. 350, Atlanta, Georgia 30342. PH: (404) 257-1760.

# PSYCHIATRY

# FRIDAY

## GEORGIA PSYCHIATRIC PHYSICIANS ASSOCIATION

### PSYCHIATRIC ASPECTS OF THE MEDICAL PATIENT

*Program Chairman:*

*Gene G. Abel, M.D., Atlanta*

The Psychiatry program will focus on how to evaluate and treat patients with medical problems who have difficulty implementing their medical management. The meeting will not focus on patients with psychiatric disorders who also have medical illnesses, but will instead discuss how we can help the medical patients accept their diagnoses and treatment and help the medical physician treat his or her medical patient.

*Faculty:*

*Steven E. Hyler, M.D.,  
Associate Clinical Professor of  
Psychiatry  
Columbia University, NY*

*Gene G. Abel, M.D.*

*Professor of Clinical Psychiatry  
Emory University School of  
Medicine, Atlanta*

*Obo Addy, M.D.*

*Assistant Professor of Psychiatry  
Associate Director of Sleep  
Disorders Ctr.  
Emory University School of  
Medicine, Atlanta*

*Michael Aronson, M.D.*

*Resident, Department of  
Psychiatry  
Emory University School of  
Medicine, Atlanta*

*Richard Elliot, M.D., Ph.D.*

*Assistant Professor of Psychiatry  
MCG, Augusta*

*John Gaston, M.D.*

*Associate Professor of Psychiatry  
Morehouse School of Medicine  
Atlanta*

*Ralph Jones, M.D.*

*Professor of Psychiatry  
MCG, Augusta*

*Bernard Kahan, M.D.*

*Assistant Professor of Psychiatry  
Emory University School of  
Medicine, Atlanta*

*Anthony Karpas, M.D.*

*Vice President, Georgia Affiliate-  
American Diabetes Association  
Clinical Instructor  
Department of Medicine  
Emory University School of  
Medicine, Atlanta*

*Peter Kim, M.D.*

*Assistant Professor of Psychiatry  
MCG, Augusta*

*Mary Jane Massie, M.D.*

*Associate Attending Psychiatrist  
Memorial Sloan-Kettering Cancer  
Center, NY*

*Barry Scalon, M.D.*

*Private Practice, Atlanta*

9:00-9:45

### ■ The Medically Ill Child

*Peter Kim, M.D.*

9:45-10:30

### ■ The Hyperventilation Syndrome: Misdiagnosis, Diagnoses, and Behavioral Treatment

*Gene G. Abel, M.D.*

*Michael Aronson, M.D.*

10:30-10:45

### ■ Coffee Break

10:45-11:15

### ■ The Non-Compliant Diabetic Patient: Assessment and Treatment

*John Gaston, M.D.*

11:15-11:45

### ■ Brief Dynamically Oriented Psychotherapy with Medically Ill Patients

*Richard Elliot, M.D., Ph.D.*

11:45-1:30

### ■ Lunch Presentation: Psychiatric Syndromes in the Cancer Patient: Diagnosis and Management

*Mary Jane Massie, M.D.*

1:30-2:15

### ■ Treating Patients with Somatization: Have We Been Aggressive Enough?

*Ralph Jones, M.D.*

2:15-3:15

### ■ Patients with Factitious Disorders: Can We Really Help Them?

*Steven E. Hyler, M.D.*

3:15-4:00

### ■ Symposium: Factitious Disorders Seen in Georgia and Their Treatment

*Obo Addy, M.D.*

*Bernard Kahan, M.D.*

*Anthony Karpas, M.D.*

*Barry Scalon, M.D.*

*Steven E. Hyler, M.D.*



## PHYSICIAN WANTED

**Clinical Director** needed to provide and promote appropriate medical standards of care and provide liaison and close working relationship with other administrative staff of the Developmental Disabilities Division which houses approximately 580 residents at Central State Hospital, a JCAHO, ACDD, and Medicare/Medicaid-certified facility located in middle Georgia. State service provides excellent fringe benefits including free malpractice insurance. Requires: License to practice medicine in Georgia and board certification in psychiatry, pediatrics, or internal medicine. Developmental disabilities/mental retardation experience in clinical and/or administrative capacities preferred. Contact: Personnel Office, Central State Hospital, Milledgeville, GA 31062-9989; (912) 453-4094. Applications accepted continuously until suitable applicant located. AA/EOE.

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## MANUSCRIPT INFORMATION

**MANUSCRIPTS** — Articles are accepted for publication on the condition that they are contributed solely in this *Journal*. Manuscripts should be typewritten, double-spaced, and the original and one copy should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

**STYLE** — Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the following style: name of author (with initials), title of article, name of periodical, date, volume (number, if available), and pages.

Sorter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. *N Engl J Med* 1976;294:687-90.

**NEWS NOTES** — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

**REPRINTS** — Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

**ILLUSTRATIONS** — **Illustrations must be submitted in duplicate.** Illustrations, tables, etc., should bear the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication in excess of three average illustrations and/or tables will be borne by the author, and the *Journal* will bill the author for this expense.

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**MEDICAL EDITING SERVICES** — If in the opinion of the *Journal* Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publications may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.



NOVEMBER 1988

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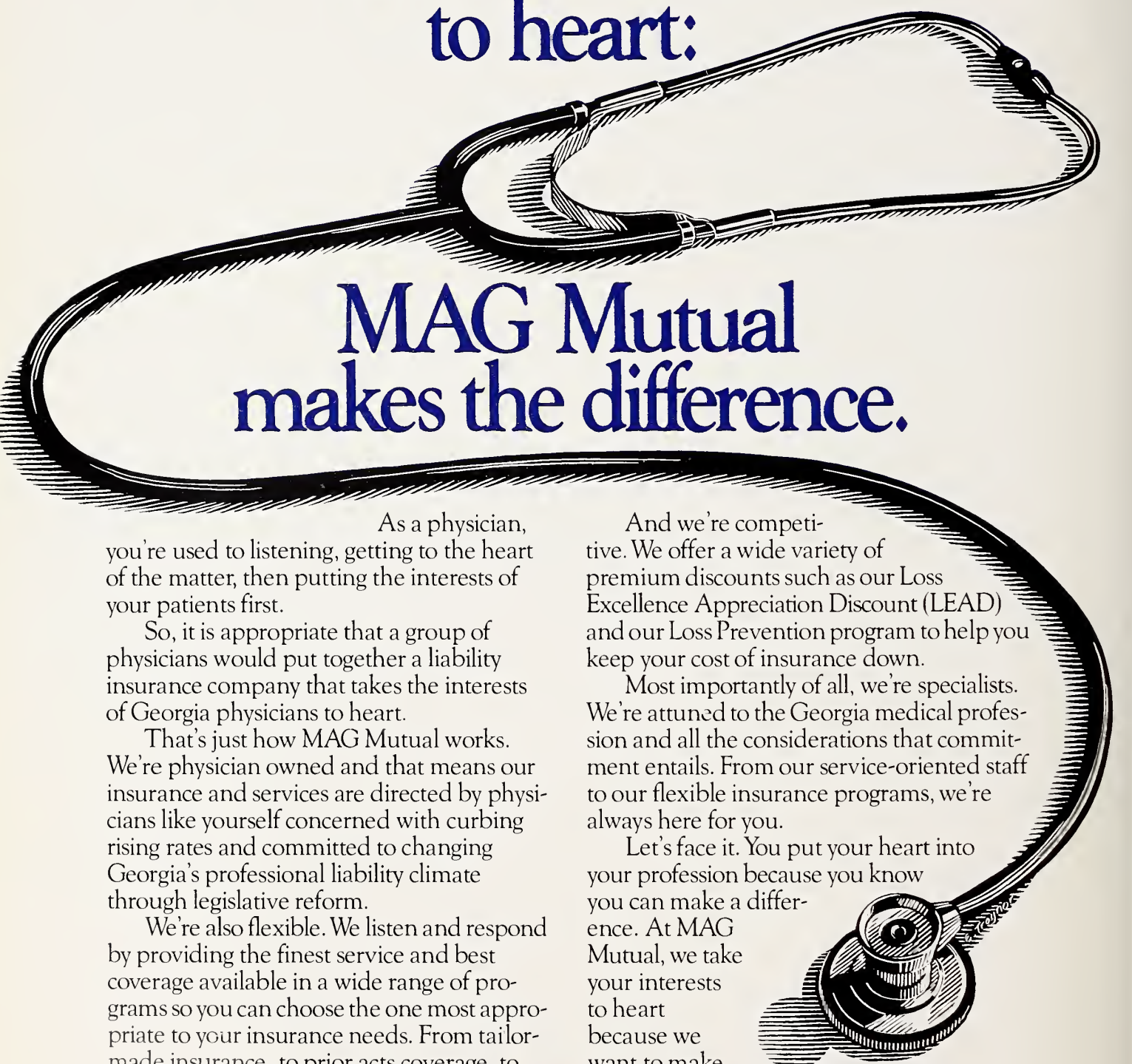
# GEORGIA

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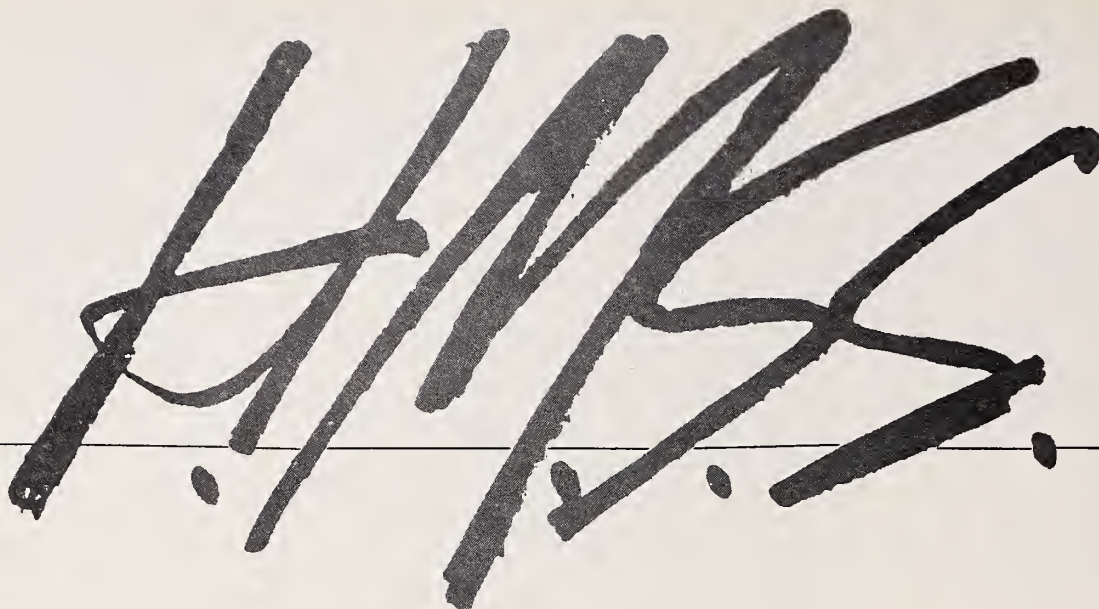
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THE COVER

Our cover art by Atlanta artist Wadsworth A. Jarrell was chosen to depict the theme of this issue, aberrations of the mind, because of the unusual facial expressions of the people in the painting. Read more about this artist on page 807. Entitled "Sadie's Wedding," the painting may be seen at the Douglas County Public Library. (Only a portion of the painting is shown on the cover.) Mr. Jarrell's art is handled exclusively in Atlanta by the **FAY GOLD GALLERY**, 3221 Cains Hill Pl., 30305.



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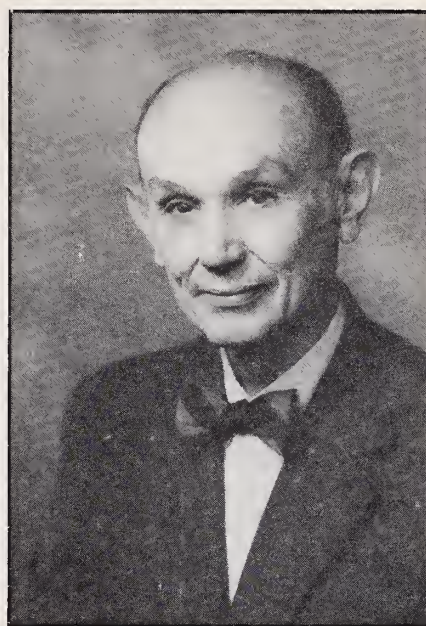
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*Joseph P. Bailey, Jr., M.D.*

**R**ECENTLY I HAVE HAD the opportunity and privilege to work with the leadership of two of our state specialty societies. The problems faced by them are of concern to us all and represent a need for change that can be positively influenced by the efforts of MAG. In developing this effort, the first necessity was for mutual understanding that evolved through communication. This sounds so simplistic, and yet it is the lack of exchange of information and subsequent understanding that often constitutes the barrier to progress. MAG's House of Delegates has moved to eliminate part of this barrier by seating specialty society representation. This action will be culminated in 1989 after the requisite repose for 1 year prior to final action.

**B**ut what is the real substance of the potential for progress through unity? I believe it is the necessity for remembering our common professional heritage as

physicians and striving to maintain the altruism which has almost disappeared from our world in this day of real and attempted governmental control and economic stress. We must maintain a genuine concern for each other as we do for our patients. As we are in an ever-changing world, we will also change and make progress. In order to ensure this progress, we must remember that amidst the alligators we did come to drain the swamp. We are a profession of the highest standards and quality existing on this earth. To maintain this state, we must be unified in the bond of our rich heritage and an ongoing capacity to make true progress through change. To be divided is to ensure great difficulty if not blatant failure. To be unified requires understanding and the willingness to accept variance of approach and opinion while maintaining individuality and integrity.

*Joseph P. Bailey, Jr.*

## PERSONALS

### Georgia CMS



(Top Photo): Savannah orthopedic surgeon Joe Nettles, former Chairman of MAG's Board of Directors, and Ann Purcell (Mrs. Dent W.), of Savannah, Past President of the Auxiliary to the MAG and a member of the Georgia Medical Society, present Georgia Congressman L. Thomas (center) with a check from GaMPAC.

(Bottom Photo): Mrs. Purcell presents Georgia Representative Clinton Oliver with a contribution from GaMPAC.



### Hall CMS

**Ellis B. Kenner, M.D.**, a neurosurgeon in Gainesville, has been appointed by Gov. Joe Frank Harris to the Composite State Board of Medical Examiners.

### Oconee Valley CMS

**James E. Sutherland, M.D.**, of Greensboro, GA, has been elected to the Greene County Hospital Authority.

### Muscogee CMS

**Alan S. Peiken, M.D.**, of Columbus, has been named Professional of the Year by the American Lung Association of Georgia. Dr. Peiken is chief of pulmonary medicine at The Medical Center in Columbus.

The American College of Nuclear Medicine bestowed its highest honor, the Gold Medal, on **John D. Watson, Jr., M.D.**, of Columbus, GA, at a convocation of the college last September. The medal, only the fifth to be awarded, was given in recognition of Dr. Watson's efforts and achievements in the development and progress of the college.

Dr. Watson, a charter fellow and past president, is currently chairman of the Board of Representatives and Executive Director of ACNM. He is a Fellow of the American College of Radiology, a past councilor and member of the Steering Committee, and is now serving as a chancellor of ACR.

On the state level, Dr. Watson is a past president of the MAG and the Georgia Radiological Society and is now president of the Georgia Society of Nuclear Medicine. He is a member of the House of Delegates of the AMA and chairs its Section on Nuclear Medicine.

In November, 1987, he was program director for an international symposium on imaging held in Beijing, China,

under the auspices of the International Foundation for Scholarly Exchange.

## DEATHS

**Frank Blaydes, M.D.**, a family practitioner who practiced in Hahira and Lake Park, died when the single-engine plane he was flying in dense fog crashed into the tower of a Valdosta television station.

**William E. Huger Jr., M.D.**, of Atlanta, chief of plastic surgery at Piedmont Hospital, died after a heart attack while vacationing at Highlands, N.C. He was 62.

Dr. Huger had been with Piedmont Hospital since 1963, and was a clinical assistant professor of surgery at Emory University School of Medicine.

Dr. Huger was president of the American Society of Plastic and Reconstructive Surgeons from 1979 to 1981 and at his death was a trustee of the group. He also was a former president of three other organizations — the Medical Association of Atlanta, Southeastern Society of Plastic and Reconstructive Surgeons and Georgia Society of Plastic Surgeons — and a member of several other professional organizations.

**J. Harry Rogers, M.D.**, a retired Atlanta surgeon, died last August at the age of 86.

Dr. Rogers was a graduate of University of Georgia and Emory University School of Medicine, and was Chief of Surgery at Crawford Long Hospital for many years. He was the physician for the Atlanta Crackers, and later for the Atlanta Braves.

Dr. Rogers served in the U.S. Navy in the Pacific during World War II. He was captain in the Naval Reserve and was awarded the Bronze Star for military service.



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<sup>1</sup> N.I.H

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### BRIEF SUMMARY

#### CONTRAINDICATIONS

There are no known contraindications to the use of sucralfate

#### PRECAUTIONS

Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

**Drug Interactions:** Animal studies have shown that simultaneous administration of CARAFATE (sucralfate) with tetracycline, phenytoin, digoxin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The clinical significance of these animal studies is yet to be defined. However, because of the potential of CARAFATE to alter the absorption of some drugs from the gastrointestinal tract, the separate administration of CARAFATE from that of other agents should be considered when alterations in bioavailability are felt to be critical for concomitantly administered drugs.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** Chronic oral toxicity studies of 24 months' duration were conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). There was no evidence of drug-related tumorigenicity. A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies were not conducted.

**Pregnancy:** Teratogenic effects. Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

**Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

**Pediatric Use:** Safety and effectiveness in children have not been established.

#### ADVERSE REACTIONS

Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients treated with sucralfate, adverse effects were reported in 121 (4.7%).

Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

#### OVERDOSAGE

There is no experience in humans with overdosage. Acute oral toxicity studies in animals, however, using doses up to 12 gm/kg body weight, could not find a lethal dose. Risks associated with overdosage should, therefore, be minimal.

#### DOSAGE AND ADMINISTRATION

The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

#### HOW SUPPLIED

CARAFATE (sucralfate) 1-gm tablets are supplied in bottles of 100 (NDC 0088-1712-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1712-49). Light pink scored oblong tablets are embossed with CARAFATE on one side and 1712 bracketed by C's on the other.

Issued 1/87

#### Reference:

1. Eliakim R, Ophir M, Rachmilewitz D: *J Clin Gastroenterol* 1987;9(4):395-399.

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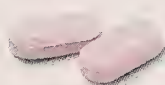
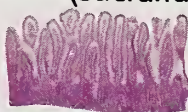
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## About the Cover Artist

# Wadsworth A. Jarrell

ON THE COVER THIS MONTH is part of a painting by Wadsworth A. Jarrell entitled, "Sadie's Wedding." Though the title itself does not relate, we thought the expressions on the people's faces suggested aberrations of the mind, the theme of this issue of the *Journal*.

Born in Albany, Georgia, Mr. Jarrell was educated at the Ray Vogue School of Art in Chicago and earned his B.F.A. at the Art Institute of Chicago and M.F.A. at Howard University of Washington, D.C. He now lives in Atlanta and has been Professor of Art at the University of Georgia in Athens since 1978. Prior to that, he was Assistant Professor of Art at Howard University.

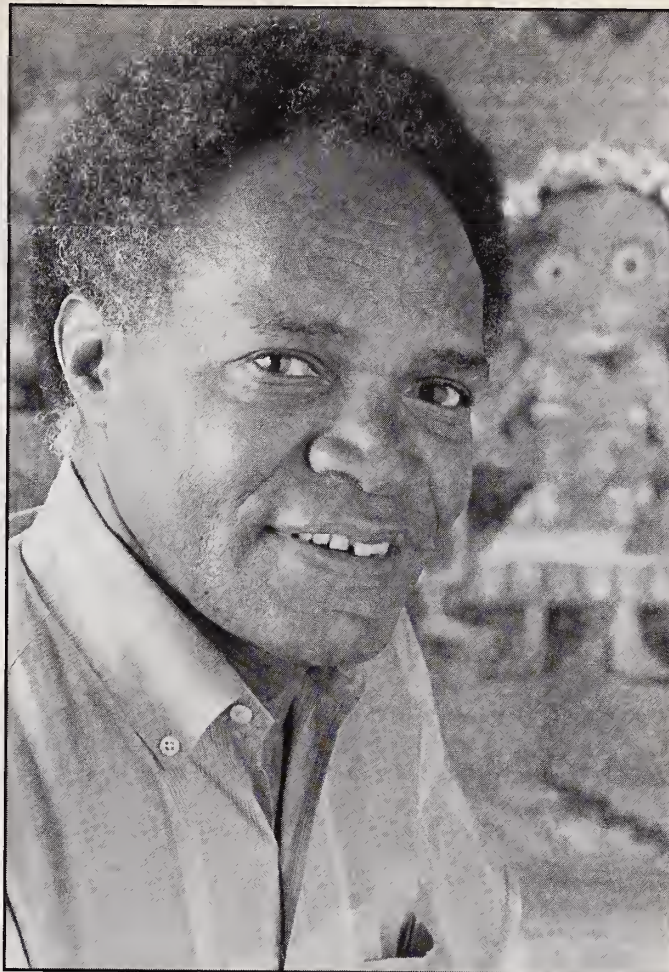
Mr. Jarrell was one of the founding members of the AFRICOBRA (African Commune of Bad Relevant Artists), founded in Chicago in 1968. This multi-faceted group of artists came together to explore new and innovative ideas in art, relating directly to African American people in the USA. The AFRICOBRA, Creators of "Poster Art," has exhibited in more than 50 American cities, the Caribbean, and Africa.

### Select Group Exhibitions

AFRICOBRA 1988, Fay Gold Gallery, Atlanta  
The Eighth Annual Atlanta Life National Art Competition Exhibition, Atlanta  
AFRICOBRA U.S.A. 16eme Festival Culturel, Sermac, Fort De France, Martinique, French West Indies  
Birmingham Biennial, Birmingham Museum of Art, Birmingham, AL  
AFRICOBRA in Detroit, G.R. N'Namdi Gallery, Detroit, MI  
Inside Out, Malmo Konsthall, Malmo, Sweden  
Atlanta in France, Chapelle De La Sorbonne, Paris  
Portrait of the South, Palazzo Venezia Museum, Rome, Italy  
Second World Black and African Festival for the Arts, National Theater Gallery, Lagos, Nigeria  
2nd Africa-American and Diaspora Festival for the Arts, Port-au-Prince, Haiti  
Chicago International Art Exposition, Navy Pier, IL  
Dimensions and Directions, Mississippi Museum of Art, Jackson, MI  
Artists in Georgia Show, High Museum of Art, Atlanta

### Select One-Man Exhibitions

Paintings and Drawings, Wadsworth Jarrell, Chicago  
Fine Arts Center, Chicago  
Going Home, Howard Art Gallery, Washington, DC  
The Works of Wadsworth Jarrell, Carriage House Gallery, Richmond, VA  
Albany Museum of Art Presents — Wadsworth Jarrell, Paintings, Albany, GA  
The Power and The Glory, Visual Arts Gallery, University of GA, Athens  
New Works, Wadsworth Jarrell, WJ Studios and Gallery, Chicago, IL



### Commissions

Northern Telecom, Northern Telecom Building, Sandy Springs, GA  
Westinghouse Mural, Westinghouse Electric Company, Athens, GA  
Harambee House Mural, Harambee House Hotel, Washington, D.C.  
Record Album Cover, Bill Harris in Paris and Washington, D.C.  
OK Cafe, Mural, Atlanta

### Awards

1st Prize in Painting, The Eighth Annual Atlanta Life National Art Competition and Exhibition, Atlanta  
Award for Excellence in Painting, Southern Homes Exhibition, Atlanta  
1st Prize in Painting, Oak Park Art Festival, IL  
2nd Prize in Painting, Park Forest Art Festival, IL

### Collections

The High Museum of Art, Atlanta  
The Coca Cola Company, Atlanta  
The Carriage House Gallery, Richmond, VA  
John Wieland Homes Collection, Atlanta  
King and Spalding Law Firm, Atlanta  
Cultural Affairs Bureau, City of Atlanta

Mr. Jarrell's paintings are handled in Atlanta exclusively by the FAY GOLD GALLERY, 3221 Cains Hill Place, Atlanta, GA 30305; 404-233-3843. "Sadie's Wedding" may be seen at the Douglas County Public Library.



# MRI UPDATE

## MRI Advances the Detection of Avascular Necrosis

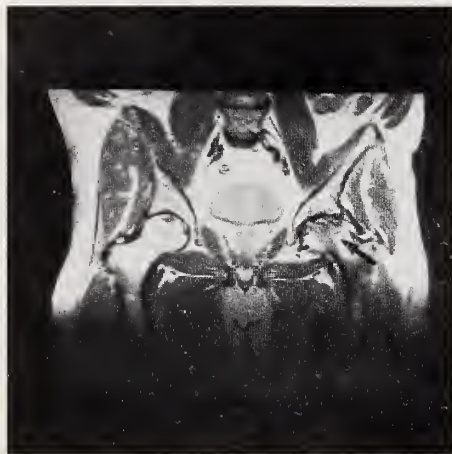


Figure A



Figure B

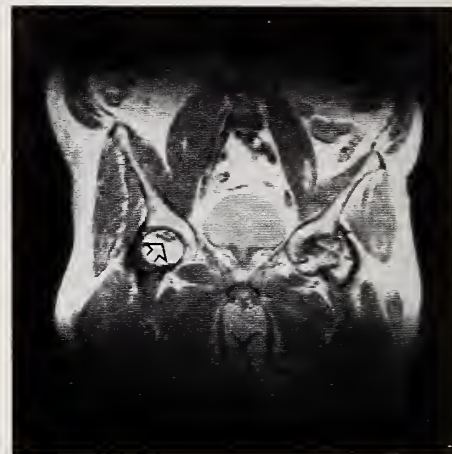


Figure C

**HISTORY:** This patient is a 50 year old male presenting with left hip and leg pain. There was no history of trauma. The radiographs of the left hip suggest advanced avascular necrosis (AVN). Radionuclide bone scan revealed non-specific generalized increased radioactivity involving the entire left hip, and the right hip was normal.

**SCAN:** Both hips were imaged in axial and coronal projections. The left hip has multiple findings consistent with advanced AVN, such as: (a) irregular low signal areas mixed with high signal areas involving the superoanterior left femoral head [Fig. A], (b) irregularity and flattening of the articular surface of the femoral head indicating fracture and collapse of the articular surface, (c) large effusion in the joint capsule [Fig. B]. The right hip reveals early changes of AVN, characterized by a low signal intensity margin around a central area of increased signal intensity involving the superoanterior femoral head [Fig. C]. No associated fracture, collapse, or evidence of joint effusion is demonstrated in the right hip.

**MRI HIGHLIGHTS:** The advantage of MRI in this study is twofold: (1) MRI corroborated radiographic findings of advanced AVN in the left hip, and, (2) MRI disclosed the incidental finding of early AVN in the right hip which was not clinically or radiographically evident. MRI is the most sensitive imaging technique for early detection of AVN, increasing the success of surgical treatment (core decompression). Although the clinical symptoms may be unilateral, the process may be bilateral; occult lesions are most likely to be missed by bone scintigraphy and CT scan. Radiographic changes are not evident until marked bone destruction has occurred.



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## *The Captain of My Soul*

***“In the course of the remarks that day, he said to the audience, “At one time in the life of every person in this room, for fleeting and brief or longer intervals, you have all been insane.” Later I told him I saw myself as stable, controlled, respected, sane. “Really?”, he asked.*”**

*I am the master of my fate;  
I am the captain of my soul.*  
(Henley)

**T**HERE IS A FINE LINE, a fine white line, between sanity and in-sanity.

I was asked, as a guest, to attend a luncheon meeting of our local Rotary Club once in the distant past. One needs, for varied and essential and some non-essential reasons, to belong to such organizations. The organizations so nurtured tend to further laudable aims as well as further those relationships which enrich our social and business life. In fact, however, I never have belonged to one, though the loss is mine. Civic clubs as such lend richness and value to life and nurture one's community.

But back to the luncheon. My friend, a psychiatrist, had been asked to speak to this gathering of recognized citizens. In the course of the remarks that day, he said to the audience, “At one time in the life of every person in this room, for fleeting and brief or longer intervals, you have all been insane.”

And so I pondered. Surely not this mature, stable, coping survivor of the residency wars. Not *me*, even for a second, insane, out of control, or crazy. “You must be out of your mind,” I said to myself. To my friend, I said, “I view myself as stable, controlled, respected, sane.” “Really?” he responded.

Time passed as our friendship deepened. Passed as he found rest from his own agony in death. Passed as I thought over that remark. Is it, this matter of sanity, merely a thing of degree? Or the *time* it occupies of our daily life? Are we, each of us, truly insane or psychotic for brief moments of our life? Or for major portions of those lives? Are the moods of our days truly dependent on forces beyond our control — the weather, atmospheric pollution, our serum magnesium level, the kiss we received, or did not receive, as we left for work? Are we, indeed, the masters of our fates, the captains of our souls? It is a shattering thought — that we are subject to forces beyond our understanding and independent of our control.

**I** have been told, and this by others who spend their days toiling with the afflicted of mind and habit, that to be a good psychiatrist, to be well trained, one must know the writings of Sir James George Frazer. He wrote a book called *The Golden Bough* and presented it as a study in magic and religion. In it, he explored the habits and taboos of a great number of peoples around the earth. As one reads his description of the practices of various tribes of people, seen against the backdrop of history, the behavior of those bereft of sanity comes clearly through. He talks, for instance, in one place of “the perils of the soul”:

*It is a common rule with primitive people not to waken a sleeper, because his soul is away and might not have time to get back; so if the man wakened without his soul, he would fall sick. If it is absolutely necessary to rouse a sleeper, it must be done very gradually, to allow the soul time to return. A Fijian in Matuku, suddenly wakened from a nap by somebody treading on his foot, has been heard bawling after his soul and imploring it to return. He had just been dreaming that he was far away in Tonga, and great was his alarm on suddenly awakening to find his body in Matuku. Death stared him in the face until his soul could be induced to speed at once across the sea and reanimate its deserted*

*tenement. . . Now the absence of the soul in sleep has its dangers, for if from any cause the soul should be permanently detained away from the body, the person thus deprived of the vital principal must die. There is a German belief that the soul escapes from a sleeper's mouth in the form of a white mouse or a little bird, and that to prevent the return of the bird or animal would be fatal to the sleeper. Hence in Transylvania they say that you should not let a child sleep with its mouth open, or its soul will slip out in the shape of a mouse and the child will never wake.*

It is said of Sir James George Frazer that he read voraciously to the point that in his old age blindness afflicted him. He is thought to have literally read himself blind. It asks too much of this surgeon, however, that he lose his vision in the search for understanding. Or the search for

sanity, for that matter. Nonetheless, in the repetitive daily task of meeting the rising sun must one include that effort to know his or her self. To spend a bit of time, as did Montaigne, to look inward and study what might be seen there. To know thyself and then, and should indeed the yet unproven thesis be correct, to face with fearless resolution the task of correcting those errors of character and conduct which confront us.

There is an ancient Chinese proverb — there are so many that one must doubt them all save those that have come to us through the master, Confucius — which says, "The important thing is this. To give up what you are for what you might become."

One grasps the plunger of the syringe holding the next dose of Demerol. Looks lovingly at the white powder and the coiled roll of paper poised at the

nostril. Slowly twists away the cap of the bottle labeled "Schedule No. II." With careless abandon, removes the cork of the almost empty flagon gazing rapturously into its empty depths. Looks with loving intensity into the eyes of a psychotic child, wife, brother, or sister confused with altered thought processes. Looks and asks again, "Am I the master of my fate, the captain of my soul?"

**W**e talk this month of aberrations of the mind. They are yet poorly understood. We talk of schizophrenia, of substance abuse, of *our* problems. Of our children's problems. Of our wives' problems. We talk as we have for so long since those days of training of the problems of our fellow beings. Read these articles carefully, for, "There, but for the grace of God, go I."

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# CALENDAR

## DECEMBER

3-4 — *Atlanta: Regional Anesthesia: Surgery, Obstetrics, and Pain.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

5-9 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

7-9 — *Atlanta: Nuclear Medicine Update: Infection, Renal, and Cardiac Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

9 — *Atlanta: Current Topics in Rheumatology for the Non-Specialist.* Category 1 credit. Contact Frederic C. McDuffie, M.D., Piedmont Hospital Arthritis Center, 1968 Peachtree Rd., Atlanta 30309. PH: 404/350-1750.

12-16 — *Atlanta: Modern Methods of Diagnosing and Treating Diabetes Mellitus and Its Complications.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

## JANUARY 1989

9-13 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

23-27 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

23-27 — *Atlanta: Modern Methods of Diagnosing & Treating Diabetes Mellitus & Its Complications.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

## FEBRUARY

6-10 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

6-10 — *Atlanta: Modern Methods of Diagnosing & Treating Diabetes Mellitus & Its Complications.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

10-11 — *Augusta: Flexible Fiberoptic Sigmoidoscopy.* AMA Category 1 credit and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

11-18 — *Copper Mountain, CO: New Horizons in Anesthesiology.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

18-22 — *St. Thomas, Virgin Islands: Clinical Problems in Gynecologic Surgery.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

20-24 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

20-24 — *Atlanta: Modern Methods of Diagnosing & Treating Diabetes Mellitus & Its Complications.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

## MARCH

2-9 — *Keystone, CO: Snow Job in Gynecology & Obstetrics.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

3-4 — *Atlanta: 26th Annual Emory/Grady Post-Graduate Ophthalmology Conference.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

6-10 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

6-10 — *Atlanta: Modern Methods of Diagnosing & Treating Diabetes Mellitus & Its Complications.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

6-11 — *Augusta: 24th Annual Primary Care & Family Practice Symposium.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

9-11 — *Sea Island: Critical Care at the Cloister.* Category 1 credit. Contact Mercer Univ. Sch. of Med., Office of CME, Macon 31208. PH: 912/744-1634.



# LETTERS

Dear Editor,

I agree with the editorial by Dr. Lovick Dickey (August '88 *JMAG*) that medical costs and services are getting out of hand and that some system for rationing is needed. Rationing was a normal physician function at one time, but the tort explosion and the Baby Doe Act has made that impossible. The PRO sanctions the least costly providers such as rural family practitioners for not utilizing the latest technology. Physicians in our hospital have been sanctioned for failure to anticoagulate a 90 y/o Alzheimer patient with a small lacunar infarct. Government through PROs and the court system have guaranteed that all patients, regardless of their prognosis, will get the latest high tech care.

I do not believe that our current political structure has the courage

to lay out policy as to who gets what treatment, i.e., rationing.

In the absence of real tort reform and written guidelines from a political body, the reality is that money will be rationed but not medical care. God help those that get caught in the middle.

Sincerely,  
*Olav H. Alvig, M.D., P.C.*  
*Radiologist, Cumming*

Dear Editor:

It is felt that you should send copies of articles in September issue of *Journal of Medical Association of Georgia* to each Georgia Senator, State and National, plus the Representatives.

This would be even better if you requested that each member whom you may contact (at least 50%) would endorse that the

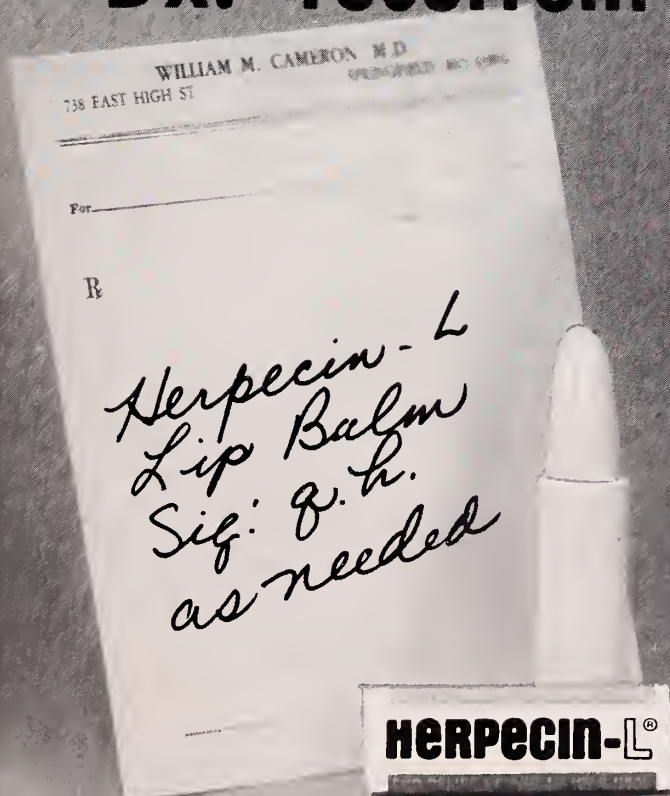
representatives read such articles and reply to the physicians from each area. This would truly help the rapport with each. I think copies of: 1. Uncompensated Health Care in Georgia by Ann Marchetti 2. Uncompensated Medical Care by J. Rhodes Haverty, M.D. 3. The Cost of Compassion by Joseph Parker 4. The Medically Uninsured: Who Cares? by Betty C. Castellani should be sent.

If this is too big a job, pass part of this to each medical secretary. This is the time to make some effort to show that physicians are caring persons instead of leeches.

This is a real opportunity to help. Please let me hear from you.

Sincerely yours,  
*David C. Williams, Jr., M.D., P.C.*  
*Urologist, Augusta*

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# Quiet Thoughts

From BYNUM'S scrap book . . .

*"If I should die and leave you here awhile,  
Be not like others, sore undone, who keep  
Long vigil by the silent dust and weep.  
For my sake, turn again to life and smile,  
Nerving the heart and trembling hands to do  
Something to strengthen lesser souls than thine  
Complete those dear unfinished tasks of mine,  
And I perchance, in them, will comfort you."*

ATTRIBUTED TO A FORMER PRESIDENT  
OF VANDERBILT UNIVERSITY.

**I** AM REMINDED of a comic that was circulated recently:

Two middle aged ladies were chatting over a cup of tea, Mrs. Grimhaus & Mrs. Hobbs.

Mrs. Grimhaus: "My fourth husband, Mrs. Hobbs, I'll never forget his last words."

Mrs. Hobbs: "His last words, Mrs. Grimhaus, what were they?"

"They were: 'My darling, we don't have much longer to be together, so promise me you will keep my memory alive. When you think of the time we were allowed to share, try always to recall the happy moments, . . . The laughter, the joy. . . As that is how I wished to be remembered. Please don't languish in sorrow, nor yearn hopelessly for me, dearest one. . . For now you must be very strong, and go on in life, our beloved children need you, for fate has decreed that you, and you alone, must see to their hopes and dreams we had for their futures.' "

(sigh) "A heartbeat later, he was gone!!"

Mrs. Hobbs: "OH, what a pity, such a lovely man DIED!!!!"

Mrs. Grimhaus: "Who died???"

"The rat flew to RIO with his secretary!!!"

*Richard Bynum Weeks, M.D.  
Saint Simons Island*

*We invite contributions to this Department. Please send them c/o the Journal,  
938 Peachtree St., Atlanta 30309.*



### Hospitals Support Amendment 14

One of the amendments that will appear on the November 8 ballot is Amendment 14, or the Indigent Care Trust Fund Amendment. The amendment would allow the Georgia General Assembly to create a trust fund that could be spent to increase the number of persons who are eligible for Medicaid coverage.

The Georgia Hospital Association points out that uncompensated health care is currently costing the state's hospitals more than \$1 billion each year, and a great percentage of that amount is the cost of providing care to patients who are poor, but not poor enough to qualify for Medicaid.

To encourage the passage of the amendment, GHA is preparing fliers to send to hospitals and physician offices to distribute to patients as well as posters to display in patient areas. Hospital administrators will also send letters in support of the amendment to their local papers.

### High School Students are Target of Health Careers Recruiting in Georgia

As part of its efforts to recruit high school students into health careers, the Georgia Hospital Association is participating in a state-wide tour of secondary schools sponsored by the Georgia Education Articulation Committee.

The tour, which is known as the PROBE tour, will cover schools throughout Georgia. This is the first year the tour has

included a program on health careers in general. It is an annual event in which many Georgia colleges participate. The Georgia Education Articulation Committee is an organization of educators from throughout the state whose purpose is to stimulate interest in postsecondary education.

### Georgia's Hospitals Elect to Protect Medicare

Hospitals in Georgia and throughout the country have begun a new program called "Elect to Protect Medicare." The purpose of the effort, which is led by the American Hospital Association, is to bring to light the fact that Congress has cut hospitals' Medicare payments to the extent that hospital care for all patients is affected. Through the program, hospitals are encouraging their employees and the public to ask their senators and congressional representatives to stop further Medicare cuts.

The goal of "Elect to Protect Medicare" is to bring about 1.5 million congressional contacts by concerned voters during this year and next.

In promoting the campaign, the AHA recently ran an advertisement in the *Washington Post* in which the association's president, Carol M. McCarthy, pointed out the problems Medicare cutbacks have caused. Among the points the advertisement makes are these:

- What good is a new drug to a heart attack victim if the hospital can't afford to buy it?
- How good is the best

emergency care for a rural accident victim if the nearest hospital is a 40-minute ambulance ride away?

- What good is a hospital if it can't afford to hire enough nurses?

McCarthy also stated that Congress has a choice: "to review the nation's commitment to Medicare or to turn its back on the elderly and disabled and continue to undermine the provision of essential health care services."

### Hospitals are Analyzing Their Medicare Mortality Rates

Hospitals throughout the country have not received their Medicare mortality data from the Health Care Financing Administration.

The HCFA data give last year's Medicare mortality rates for 16 diagnostic categories. Hospitals have until October 21 to respond to the data, and the numbers, plus the response, will then be released to the public December 17.

Because many hospitals last year said the data did not reflect the severity of illness of their patients, HCFA has now made available a new software package that lets the hospital determine the expected mortality rates for its individual patients. The software, Medicare Mortality Prediction System, can evaluate only four of the 16 diagnoses. It is also capable of giving a projected death rate for the patients of individual physicians.

*This Department is sponsored by the Georgia Hospital Association*

# THE ARMY RESERVE OFFERS NEW FINANCIAL INCENTIVES FOR RESIDENTS.



If you are a resident in Anesthesiology or Surgery\*, the Army Reserve has a new and exciting opportunity for you. The new Specialized Training Assistance Program will provide you with financial incentives while you're training in one of these specialties.

Here's how the program can work for you. If you qualify, you may be selected to participate in the Specialized Training Program. You'll serve in a local Army Reserve medical unit with flexible scheduling so it won't interfere with your residency

training, and in addition to your regular monthly Reserve pay, you'll receive a stipend of \$678 a month.

You'll also have the opportunity to practice your specialty for two weeks a year at one of the Army's prestigious Medical Centers.

Find out more about the Army Reserve's new Specialized Training Assistance Program.

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## **ARMY RESERVE MEDICINE. BE ALL YOU CAN BE.**



## New Age Psychiatry: Peter Pan Arrives

Dave M. Davis, M.D., F.A.P.A.

FOR MANY YEARS, we psychiatrists have wandered the Wild West of medicine, wondering if we were ready for prime time. We have waddled like the wagonmaster among the wagons of neurosis, psychosis, and organic disease. Our best efforts have been directed towards understanding why the cowboy kisses the lady, but we have lacked drills and shovels to pierce the mountain's mantle and mine the chemical/physical ore of the substrata.

Our theories, while often very insightful, have been embedded in chunky scoops of Procrustean dogma. By speaking a brand of Freudian Esperanto, we created a psychologic fissure between us and our non-psychiatric colleagues.

Technology to the rescue?! Computerized tomography, PET scanners, and MRI seem to be dividing old territories into brand new subdivisions. Can obsessive-compulsive disorder really be due to a lesion in the brain? Along with the micro-analyses of neurotransmitters, these computerized seeing-eye dogs are providing us a peephole on the active brain at work.

While it may be some time before we burn our couches (and I hope psychiatrists will always be doctors who talk to their patients), psychiatrists now seem closer to joining the elite club of real doctors. Peter Pan

arivisit . Well, at least we have entered the stadium.

This issue of the *Journal of the MAG* presents some of the new information about schizophrenia,

depression, suicide, panic attacks, adolescent substance abuse, and obsessive-compulsive disorder. Read them and expand your understanding and horizons.

## The Adolescent Urine Drug Screening Program

Dirk E. Huttenbach, M.D.

ON SEPTEMBER 14, 1988, MAG sent out a news release; announcing that the Georgia Congress of Parents and Teachers, and the Council for Children, Inc., had joined it in endorsing the Adolescent Urine Drug Screening Program initiated by the Cobb Country Medical Society in June, 1985.

Public support for this program is obviously growing. The public may soon approach individual county medical societies with requests that similar programs be made available through local medical societies and local hospitals to show concern for adolescents and families in our communities who are facing the dangers of adolescent drug abuse.

Presidents of all Georgia county medical societies received a letter in June, 1986, from John D. Watson, Jr., M.D., then President of MAG, and James A. Kaufmann, M.D., MAG's Speaker of the House, encouraging them to set up similar programs in their local jurisdictions. Five Georgia

medical societies have now made this program available (Cobb, DeKald, Muscogee, Clayton, and Fulton).

We encourage the other 61 medical societies to join as well to make this valuable yet simple and inexpensive public health program available to all Georgia communities.

Caring medicine makes for good will for the medical profession. This program provides an excellent opportunity to earn increased good will.

Please support this program by asking your local medical society president to start a similar one in your area. Better yet, volunteer to head up a committee or sub-committee to accomplish this. Once the program is set up, which is fairly simple, there is not that much work. Please also remember that any decrease in adolescent drug abuse in your community makes life safer for your own children and grandchildren. For further information on how to implement this program in your community, please contact Mrs. Cam Taylor, Director of Medical Practice, MAG, 938 Peachtree St., Atlanta, GA 30309; (404) 876-7535, 800-282-0224 in Georgia.

Dr. Huttenbach practices psychiatry and is President, Georgia Council for Child and Adolescent Psychiatry, and Chairman, Subcommittee on Adolescent Drug Abuse, Cobb County Medical Society. His address is 833 Campbell Hill St., Marietta, GA 30090.

Dr. Davis is Chairman of the Medical Association of Atlanta's Mental Health Committee. His address is 1938 Peachtree St., Ste. 401, Atlanta, GA 30309.

# The Future Effect Of AIDS On Your Insurance Plans

## Answer This Question:

If in the 1970's and early 1980's you had known what you know now about medical malpractice premiums, would you have been willing to purchase your coverage on a fixed, guaranteed cost basis?

Of course you would.

That type of opportunity exists today in an area that is likely to be as volatile as the malpractice area has been. I am referring to nonguaranteed life and disability plans.

The spectre of AIDS is casting a long shadow in the insurance community. Because of actual claims and expected claims, most nonguaranteed plans, and plans offered by companies that are not rock solid, will be severely affected. Unless you are positioned properly, you will see a doubling and tripling of your insurance rates,

and many plans will be cancelled altogether.

Professional Resource Group works only with physicians. We are committed to helping them keep their plan costs as low as possible without sacrificing quality.

Though costs can not be guaranteed on medical insurance, thousands of dollars can be saved each year; in fact, Professional Resource Group was able to offer an **annual savings in excess of \$19,000** for a medical practice in Atlanta.

## Compare:

Sample rates for one of our medical plans are listed below. It is with an "A+ rated" carrier and is priced very competitively.

Typical Association Rate  
as of 10-01-87  
\$300 Deductible

AGE	EMPLOYEE	FAMILY
Under 35	\$ 50.00	\$157.00
35-39	\$ 63.00	\$189.00
40-49	\$ 93.00	\$260.00
50-59	\$148.00	\$370.00
60-64	\$211.00	\$498.00

\*A+ Rated" Carrier  
as of 05-01-88  
\$250 Deductible

AGE	EMPLOYEE	FAMILY
Under 29	\$ 34.00	\$ 91.00
30-39	\$ 38.00	\$113.00
40-44	\$ 49.00	\$127.00
45-49	\$ 59.00	\$142.00
50-54	\$ 70.00	\$155.00
55-59	\$ 84.00	\$169.00
60-64	\$101.00	\$186.00

\*The "A + Rated" carrier's premiums would be slightly higher in the Atlanta area. Rates and contracts are subject to change. A number of options are available including Maternity, Prescription, Dental, etc. at additional premiums. All premiums are subject to underwriting acceptance.

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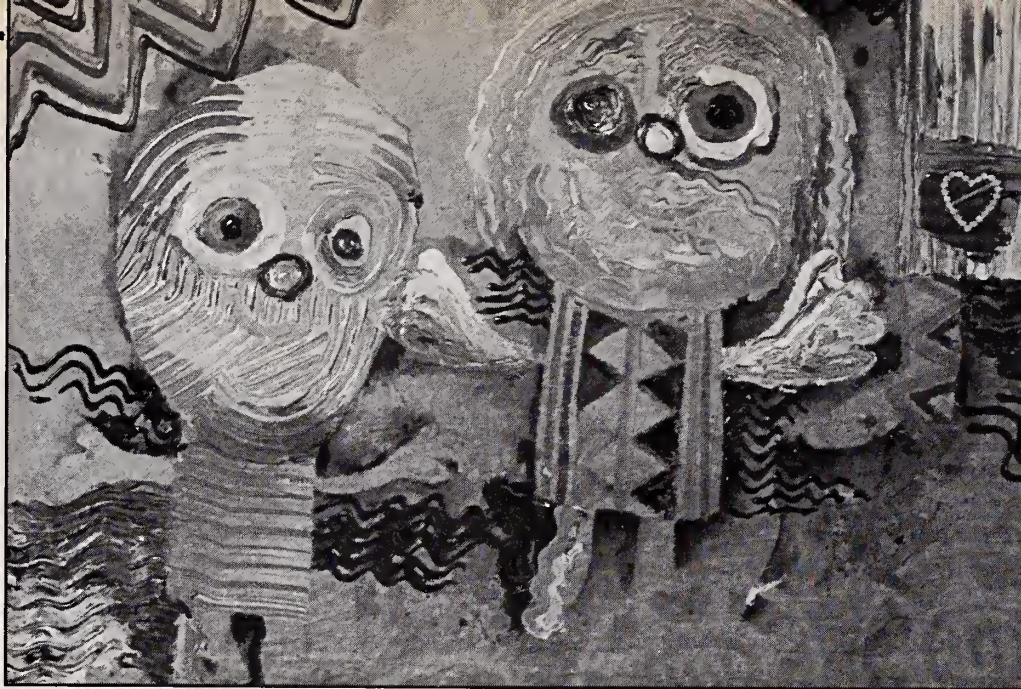
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# Adolescent Substance Abuse

D. Michael Lewis, M.D.

**D**RUG AND ALCOHOL ABUSE constitutes a major health problem for adolescents. The increasing prevalence and adverse consequences of adolescent alcohol and drug abuse must be a concern for all who work with adolescents. This article will present substance abuse as a stage along a continuum from substance use to substance dependence. Some specific areas of inquiry are suggested to help diagnose substance abuse and addiction, and recommendations for the initiation of treatment are provided.

Persistent, careful, and comprehensive investigation is the key to the difficult process of diagnosing adolescent alcohol and drug abuse. The diagnosis of adolescent substance abuse is made in an oblique fashion, in contrast to the diagnosis of such medical disorders as diabetes, which can be made through laboratory testing. The diagnosis of adolescent substance abuse is achieved most often with indirect evidence. Alcoholism/drug abuse is a disease of denial. The adoles-

cent will use every conceivable maneuver to convince the physician that he or she does not have a problem. However, there are certain clues that will enable the physician to identify the adolescent with potential problems.

## Diagnosis

There is frequently no clear delineation between appropriate use of a psychoactive substance and abuse or dependence. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III) defines substance abuse as a pattern of pathologic use with problematic consequences in some aspect of a person's social or occupational functioning. Dependence is manifest when tolerance or physical withdrawal is present.<sup>1</sup>

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Because of difficulties in the distinction between abuse and dependence, the revised addition of the DSM-III (DSM-III (R)) attempts, in its classification, to attach meaning to the diagnosis by offering a descriptive approach to the diagnosis. The focus is not so much on abuse vs. dependence as it is on behavior that signifies serious involvement with a psychoactive substance. This behavior may range from a persistent desire to reduce the use of the substance to characteristic withdrawal symptoms.<sup>2</sup>

A more simplified method of diagnosis might be to say that one has an alcohol or drug problem when use continues in spite of adverse consequences. All of the above diagnostic criteria, however, must be translated into behavior.

## Characteristic Behaviors

The use, abuse and, finally, addiction to alcohol and drugs can be conceptualized along a continuum. Along this continuum, certain emotional and behavioral symptoms in-



dicating the progression towards an alcohol or drug problem.

Drug Use → Drug Abuse →  
"Crossing the Wall" → Addiction

The average age of first use is 11.9 years for boys and 12.7 years for girls.<sup>3</sup> The first use is almost always related to peer pressure, although in some instances parentally supervised drinking may occur.<sup>5</sup> This may be the time of the first intoxication with resultant promises made not to drink so much the next time. Drinking alone is infrequent. Most adolescents who use drugs or alcohol fall into the stage of abuse. Characteristic symptoms include more frequent use and the emergence of a regular pattern. Hiding and lying about using occurs with gradual distancing from family members. Drugs and alcohol become a common focus among peers and are used as a symbol of communication. Frequently, legal consequences, such as DUIs, occur. At this time the adolescent has yet to "cross the wall" to addiction.<sup>3</sup> While tolerance levels begin to change and mood lability may be present, the adolescent's behavior controls the chemical.<sup>3</sup>

### "Crossing the Wall"

"Crossing the wall" implies addiction, with characteristic changes in personality and behavior. The rebelliousness of adolescence is excessive, with extreme withdrawal from family, increased isolation, and sexual promiscuity. Unmotivated and withdrawn behavior may result in school or work-related problems, such as truancy, school failure, and frequent firings from jobs. Communication patterns change to include vulgar language, fighting (either verbally or physically) with family members, resentments, and decreased ability to listen without defensive irritability. Physical symptoms may include a poor sleep pattern, low energy, and blackouts. Physical and laboratory examination may be characterized by a tired, drawn appearance, labile blood pressure, and increased liver enzymes. There is usually an associated change in friendships. No

longer are friends brought home, and no longer do the friends interact as freely with the adolescent's parents. This is frequently a time when help is considered, but also a time when denial is strong. Because of the family's "need" to deny a problem, they often believe the adolescent's repeated promises to stop using, and they delay in getting help. In the addictive process, the chemical now has control of behavior, and the adolescent's life is centered around drugs and alcohol. At this stage, the adolescent is no longer using drugs as a "curious experiment" or simply to get high. He is using drugs to block pain, discomfort, and "just to maintain."<sup>5</sup> Friends are almost exclusively alcohol and drug users. There is further deterioration of physical appearance and the onset of signs of physical withdrawal — e.g., GI complaints, flu-like symptoms, and frequent visits to emergency rooms or physicians' offices to obtain medication.<sup>5</sup> Increased feelings of aloneness occur with erosion of self-esteem. At this point, concern is now expressed by parents, teachers, and significant others, e.g., friends and siblings.

### Confronting Denial

Even though denial may be strong in a family, the family is still the system that most frequently intervenes in the process of substance abuse. Of course, the decision to seek help is affected by a number of factors, one of the most significant being the level of denial within the family system. Some families allow repeated incarcerations or even suicidal gestures before actively intervening. The primary care physician is frequently the first one confronted with an adolescent drug problem. Because of the strong family denial present, he or she may be the first to become aware of a problem within the family and feel the most helpless in managing it. A practical, realistic approach would be to begin the helping process by interviewing the adolescent and parents independently. The time with the adolescent would include physical and laboratory testing to provide more objective evidence of

substance abuse. If there is suspicion, the diagnosis will be further validated by the interview with the parents, which will probably be laden with details of changes in the adolescent's attitude, behavior, and physical appearance.

### Intervention

If the diagnosis seems reasonable, it is recommended, at this point, that one seek consultation with a psychiatrist or other mental health professional who is knowledgeable in the formal procedure of intervention.<sup>4</sup> It is imperative to arrange this meeting immediately as a means of intervening in the denial process. If the physician allows the family to delay this intervention, there is often an attempt on the adolescent's part to "return to normal" and show increased compliance within the home environment, thus validating to the parents that they were foolish to consider a problem related to substance abuse.

The description of the details of an intervention are beyond the scope of this article. It should be stated, however, that the most successful interventions occur with a professional who can involve family members and significant others in a process of confronting the chemically abusing adolescent in a nonjudgmental, sensitive, and honest way. The successful intervention leads to some acknowledgment that there is a problem and to a commitment to some course of treatment by both adolescent and family. Assessing this response will help determine the appropriateness of inpatient or outpatient treatment.

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# The Psychopharmacologic Treatment of Major Depression

Alan Stoudemire, M.D.



## Introduction

**M**OOD DISORDERS may affect anywhere from 5-8 percent of the American population at any given time. Data from the National Institutes of Mental Health Environmental Catchment Area project (NIMH-ECA) reveal that the prevalence of major depression is from 2-3 percent, of dysthymic disorder (depressive neurosis) 2 percent, adjustment disorder with depressed mood 2-3 percent, and bipolar disorder 0.3 percent in the general population.<sup>1</sup> In the general medical setting, which selects for patients in emotional distress and physical illness, prevalence rates for depression vary widely but average from 5-15 percent.<sup>2</sup>

## Patient Selection

The indications for antidepressant drugs is most clear for patients with symptoms of major depression and its melancholic and psychotic subtypes. The presence of prominent somatic or vegetative signs and symptoms, in addition to the profound mood disturbance, are rela-

tively clear target symptoms that indicate an underlying biologic disruption in central nervous system (CNS) mood regulation. This disruption is probably reflective of quantitative or qualitative dysfunction in CNS neurotransmitter systems, such as norepinephrine, serotonin, and acetylcholine (Table 1).

Other clinical indications that the patient's depression may have a biologic determinant include a previous history of depression or recurrent depressions, previous response to antidepressant or electrotherapy, and a family history of depression or suicide. Not all patients who respond to antidepressants, however, will have prominent somatic features. They may rather be plagued by severe cognitive signs of depression: low self esteem, guilt, uncertainty, pessimism, and suicidal thoughts.

The pharmaceutical armamentarium of currently available anti-

depressants include tricyclic antidepressants, monoamine oxidase inhibitors, and lithium carbonate. Tricyclic antidepressants are clearly the first drugs of choice. Monoamine oxidase (MAO) inhibitors and lithium should be reserved for use by psychiatrists experienced in their use. Although this discussion will focus primarily on the indications and use of tricyclics, the important medical side effects of MAO inhibitors and lithium will be briefly considered.

**T**he cyclic antidepressants include the traditional tricyclics (such as amitriptyline and imipramine) as well as the newer tetracyclic drug (maprotiline), the bicyclics (fluoxetine), and heterocyclics (doxepin).<sup>3</sup> For our purposes, we will continue to use the term "tricyclic," with the understanding that other cyclic drugs (such as the tetracyclic maprotiline and the heterocyclic doxepin) are in this general pharmaceutical category as well.

One hypothesis for the action of the tricyclic antidepressants is that

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the mood elevation effects of these drugs is caused by the blockade of the re-uptake of the neurotransmitters norepinephrine and/or serotonin into the pre-synaptic membrane after they have been released, thereby blocking their degradation and increasing their functional levels in the synapse.

### Dosing Regimens

The dose ranges and general properties of the tricyclic antidepressants (TCAs) are shown in Table 1. The average maintenance dose for most drugs in this category is 150 mg/day. The most prominent exceptions are trazodone (Desyrel), where the dose may be anywhere between 300 to 600 mg per day, protriptyline (average daily dose approximates 40 mg per day), and fluoxetine (20-60 mg/day).

While the side effects of the tricyclics will be considered subsequently, a few comments regarding choice of drug and methods of dosing will be presented.<sup>4</sup> In general, most of the antidepressants should be started at low, bedtime doses (25 to 50 mg) and gradually increased every third night over a 10 to 14 day period until a maintenance dose of approximately 150 mg per day is reached (with the exceptions noted above). More rapid dosing is certainly possible, but in the author's experience this regimen permits greater chances for adaptation to side effects, which if experienced too suddenly with rapid loading, often cause patients to discontinue the medication. Elderly patients usually require lower maintenance doses; however, this may be more a consequence of their inability to tolerate higher doses because of their sensitivity to side effects. Fluoxetine should be given in the morning because of its stimulant properties.

A lag time of 3 to 4 weeks may be seen before a true mood elevating effect is seen with these drugs. Patients should be counseled not to expect dramatic effects "overnight." Improvements in certain biologic abnormalities such as sleep disturbance, agitation, anxiety, and so forth may be seen early on and precede the onset of antidepressant activity. Sleep improvement in par-

**TABLE 1 — Selected Signs and Symptoms of Major (Endogenous) Depression**

Pervasive feelings of depression for at least 3-4 weeks
Hopelessness/Helplessness
Loss of Pleasure and Interest in Life
Sleep Fragmentation
Severe Anxiety and/or Agitation
Crying Spells
Loss of Appetite
Weight Loss
Decreased Sexual Interest and Sexual Dysfunction
Irritability
Psychomotor Retardation
Difficulty Concentrating
Suicidal Thoughts
Paranoid and Somatic Delusions (in psychotic subtype)

ticular is an excellent parameter to monitor for response to treatment and to assess if the dose of drug is sufficient.

There are no clear indications as to how long these drugs should be continued once an effective antidepressant effect is achieved. The general consensus is that antidepressant medication should be continued for an average of 6 to 12 months, after which a gradual tapering of drugs can be attempted, watching for signs of relapse. The importance of concurrent psychotherapy or some form of counseling to deal with the conflicts, losses, stresses, or other precipitants that caused the depression is essential. Such psychotherapy may be relatively brief and confined to the early stages of treatment.

### Side Effects

The most bothersome side effects of TCAs are anticholinergic (e.g., dry mouth, constipation, blurred vision, urinary retention, delirium, night sweats). The relative anticholinergic potential and sedating side effects of the tricyclic antidepressants are listed in Table 2. Trazodone has been described as being devoid of anticholinergic side effects, but the drug has been described as having a propensity to cause priapism in 1/6000 men treated and urinary retention in men, although these events are rare.<sup>5</sup>

The hypotensive effects of TCAs are often a primary concern and fre-

quently limit or contraindicate their use in elderly patients who are most prone to the development of orthostatic hypotension. One of the better predictors of the development of orthostasis present prior to treatment. While orthostatic affects can be partly offset by slow, low dosing, the development of hypotension that may precipitate falls and cerebrovascular and cardiac events may prohibit reaching levels that are therapeutically effective.

Demethylated or secondary tricyclics, such as nortriptyline and desipramine, as well as the tetracyclic maprotiline and the bicyclic fluoxetine, tend to have less pro-

**Tricyclic antidepressants are clearly the first drugs of choice (for major depression). Monoamine oxidase inhibitors and lithium carbonate should be reserved for use by psychiatrists experienced in their use.**



TABLE 2 — Properties of Antidepressants<sup>a</sup>

	<i>Effect on Serotonin Reuptake</i>	<i>Effect on Norepinephrine Reuptake</i>	<i>Sedating Effect</i>	<i>Anti- cholinergic Effect</i>	<i>Orthostatic Effect</i>	<i>Dose Range<sup>d</sup> (mg)</i>
Amitriptyline <sup>a</sup>	++++	++	++++	++++	++++	75-300
Imipramine <sup>a</sup>	++++	++	+++	+++	++++	75-300
Nortriptyline	+++	+++	++	++++	+	40-150
Protriptyline	+++	++++	+	+++	+	10-60
Trazodone	+++	±	+++	± <sup>b</sup>	++	200-600
Desipramine	+++	++++	+	+	++	75-300
Amoxapine <sup>c</sup>	++	+++	++	++	++	75-600
Maprotiline	+	++	++	+	++	150-200
Doxepin	+++	++	+++	++	++	75-300
Trimipramine <sup>c</sup>	+	+	++	++	++	50-300
Fluoxetine	++++	—	±	+	+	20-60

Relative potencies (some ratings are approximated) based partly on affinities of these agents for brain receptors in competitive binding studies.<sup>7</sup>

0 = none, + = slight, ++ = moderate, +++ = marked, ++++ = pronounced, ± = indeterminant.

a = Available in injectable form.

b = Most in vivo and clinical studies report the absence of anticholinergic effects (or no difference from placebo). There have been case reports, however, of apparent anticholinergic effects.

c = Amoxapine and trimipramine have dopamine receptor blocking activity

d = Dose ranges are for treatment of major depression. Lower doses may be appropriate for other therapeutic uses.

pensity for the development of orthostasis than amitriptyline (Elavil) and imipramine (Tofranil). It is difficult to predict, however, the degree of orthostatic hypotension that may develop with any of these drugs. Patients at high risk, especially, the elderly should be monitored on an inpatient basis until stable levels are reached, noticeable therapeutic response is achieved, and blood pressure remains stable. Patients with impaired left ventricular function as measured by radionuclide angiography are particularly prone to the development of orthostasis. Patients with congestive heart failure and/or liver failure usually require reduced doses. Tricyclic serum levels may be helpful in these patients to prevent the development of toxicity.

Problems may also arise in patients with cardiovascular disease, particularly those with conduction delays. On the EKG, the TCAs as a group tend to increase the P-R interval, QRS duration, QT<sub>c</sub> time and flatten the T-wave. In patients with preexisting bundle-branch disease or in cases of overdose, high degrees of AV block may develop. Patients with conduction delays may therefore progress to higher de-

grees of bundle branch block. Most tricyclics have a quinidine-like effect on the heart, thus their tendency to increase conduction time. As a serendipitous effect, premature ventricular contractions can be expected to decrease with treatment, particularly with imipramine.

### **The hypotensive effects of TCAs are often a primary concern and frequently limit or contraindicate their use in elderly patients who are most prone to the development of orthostatic hypotension.**

The other area of importance in considering the effects of the tricyclics on the heart concern potential exacerbation of congestive heart failure. Recent studies have demonstrated, however, that even pa-

tients with chronic heart disease can be treated relatively safely without adverse effects on the rhythm or hemodynamic function. Exceptions are cases in which there is severe impairment of myocardial performance or the patient is highly unstable or decompensating.

Cyclic antidepressants also tend to block the antihypertensive effects of guanethidine, methyl dopa, and clonidine and potentiate the hypotensive effect of prazosin. Tricyclics may inhibit metabolism of anticoagulants, thus leading to increased prothrombin times.

Because of their anticholinergic effects, TCAs may induce narrow angle glaucoma "crisis," delay gastric emptying, and exacerbate symptoms of dysphagia. Tricyclics generally lower seizure threshold in patients with such disorders, but exacerbation of seizures is usually not a problem if they are under good control and if therapeutic levels of anticonvulsants are maintained.

With respect to tricyclic blood levels, cigarette smoking, oral contraceptives, alcohol, and barbiturates lower antidepressant levels through hepatic enzyme induction; disulfiram (Antabuse) and amphetamine derivatives tend to raise levels.



## MAO Inhibitors and Lithium

While the specific uses and indications for monoamine oxidase (MAO) inhibitors and lithium carbonate will not be discussed here, several aspects of these drugs that may be pertinent to the medical-surgical evaluation of patients on these drugs will be briefly considered. MAO inhibitors may be used in the medical population but should not be used in patients on guanethidine or who are on sympathomimetics of any kind (e.g., methylphenidate, phenethylamine, metaraminol, ephedrine, phenylpropanolamine, epinephrine) or with narcotics or alcohol. These drugs may cause orthostatic hypotension as well. They should also not be used in patients receiving drugs with sympathomimetic actions. Patients with congestive heart failure, liver disease, or pheochromocytoma should also be excluded. These drugs also have orthostatic hypotensive effects. The possible precipitation of hypertensive crises through ingestion of tyramine-containing foods is well known. Hypertensive reactions have been reported with the concurrent use of MAO inhibitors and reserpine, methyl dopa, and guanethidine.

Lithium carbonate is indicated for patients with bipolar (manic-depressive) effective disorders. Lithium is excreted by the kidney, and rates of the excretion will be affected by advancing age or any other conditions that affect renal blood flow. Renal function (BUN, creatinine clearance) should be measured prior to institution of treatment as well as electrolytes, EKG, and thyroid function. Especially in the elderly, lithium excretion decreases with advancing age, and lower doses are sometimes required. Due to the elderly's sensitivity to lithium's side effects, lithium toxicity may appear even at levels that are normal for younger patients. Lithium-induced EKG changes include inversion and flattening of the T-wave. Sinus node dysfunction, SA block, and the development of ventricular irritability have been described, even at ther-

## Lithium carbonate is indicated for patients with bipolar (manic-depressive) affective disorders.

apeutic blood levels, although such effects are rare.

Stimulants such as methylphenidate have occasionally been suggested for use in depressed medical patients, particularly those who cannot tolerate tricyclics and MAO inhibitors or who refuse electrotherapy. Doses that have been recommended for methylphenidate are 10 mg twice daily or d-amphetamine once daily. These drugs, however, may cause agitation, restlessness, insomnia, and rebound depression. They are primarily used in patients who refuse or cannot tolerate other modalities, or when used with narcotics to prevent excessive sedation in patients with intractable pain or limited life spans.

Preliminary results with alprazolam, a triazolobenzodiazepine, indicate that this drug may be a mild effective antidepressant but without significant anticholinergic effects. The effective dose range is between 2 to 3 mg and may lead to sedation. These results should be considered to be preliminary until further validation studies are completed.

## Electrotherapy

Brief note should be made regarding electrotherapy (electroconvulsive or electroshock therapy) (ECT). ECT is the treatment of choice for patients who cannot tolerate the side effects of antidepressants, who have psychotic, severely melancholic, pseudodemented, delusional, severe obsessional depression, and who are so acutely suicidal that waiting for the lag time of the tricyclics to take effect would be dangerous. The only contraindications to ECT are the presence of CNS mass lesions, recent myocardial infarction, and a history of a malignant ventricular arrhythmia.

Porphyria, barbiturate allergy, pseudocholinesterase deficiency, and a family history of malignant hyperthermia are indications for special anesthetic modifications. Prolongs apnea may occur with severe liver disease, use of phenelzine, lithium, and cholinesterase inhibitors. Severe COPD may complicate ventilation and respiratory recovery. Patients previously treated with MAO inhibitors should have these drugs stopped 1 week prior to ECT. ECT usually causes reflex bradycardia immediately after seizure onset, followed by tachycardia (120-200 beats/min.), and increases in systolic (200-250 mm/Hg) and diastolic (110-150 mm/Hg) blood pressure.

The most common arrhythmia associated with ECT are PVCs, with most occurring after the seizure prior to spontaneous breathing. Patients at risk for malignant arrhythmias should have a cardiologist in attendance with the option of temporary pacemaker insertion. Reviews of specialized considerations in the medically compromised patients receiving ECT can be found elsewhere.

With the use of modern anesthesia to induce sedation and muscle relaxation to keep the seizure centrally focused, electrotherapy is a relatively benign procedure. It is the safest treatment for many elderly, medically compromised patients since the "at risk" time is under carefully controlled circumstances if done with a trained anesthetist or anesthesiologist, cardiac monitoring, and adequate oxygenation.<sup>6</sup>

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# Psychopharmacologic Treatment of Obsessive-Compulsive Disorder

William F. Thorneloe, M.D.

**T**he diagnosis of obsessive-compulsive disorder (OCD) has increased in the past few years, which is possibly due to both proved treatment as well as to improved recognition of the illness. Obsessive-Compulsive Disorder is a debilitating illness with near psychotic severity. The hallmarks of this illness include persistent, repetitive, and disturbing ideas and thoughts, images, or ritualistic actions. While patients see these symptoms as senseless and embarrassing, they are powerless in their attempts to resist them. Other repetitively impelled behaviors (such as substance abuse, binge eating, gambling, and sexual behaviors) are not included in this illness as they are seen as pleasurable. Obsessive-compulsive symptoms take up patients' time, interfere with their usual routine of day to day life. Patients with this disorder will rarely volunteer their symptoms due to the painful embarrassment they experience. Conversely, there is frequently pride in those who have the much more common compulsive personality disorder whose devotion to work and productivity, excessive perfectionism, restricted

ability to express emotions, lack of empathy, and indecisiveness are often worn as a red badge of courage.<sup>1</sup>

OCD may present to the primary care physician in a number of ways. Obsessional thoughts may include frequently distracting words and phrases with nonsensical and embarrassing content. Religious, sexual, violent, or disgusting themes may make a previously well functioning person become housebound for years. These patients may experience unwanted urges to harm themselves or others. Their fears are much like phobias, except patients may experience these in the absence of a phobic stimulus. For example, a meek math teacher could be terrorized that he would refer to sexual impulses in class.<sup>1</sup> Repetitive handwashing or preoccupation with contamination by germs may be seen in these people (e.g. Lady MacBeth). Compulsive checking (Is the iron turned off?) and cleaning (Is that blouse clean enough?) are often seen. Occasionally, social service agencies run into compul-

sive hoarders who are unable to throw any rubbish away. Some patients have an obsessional avoidance, such as a fear of drug addiction and refusal of appropriate treatment of any medical problem.



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## Treatment

The treatment of OCD has been a challenge since its earliest descriptions. Classic psychoanalysis has had limited success, as the introspection of the obsessive patient may be inadvertently reinforced through a focus on the past. Details may mask the patient's main issues. Brief, short-term, dynamically oriented psychotherapy may help symptom remission. Behavioral treatments focus on ritual-eliciting stimuli and attempt to block the obsessive or compulsive response. Flooding and milder forms of desensitization are occasionally used. Thought blocking, aversive conditioning, and fantasy exposure have been tried with variable results for obsessional thinking.<sup>2</sup>

There is a well known interrelation of OCD and major depressive disorder, in spite of the DSM-III-R classification of it as an anxiety disorder. Electroconvulsive therapy has also been reported to be effective in treatment-resistant cases. Novel antidepressants, neuroleptics, and anxiolytics have all been reported to show benefit in non-controlled studies, usually with a small number of cases. OCD is one of very few psychiatric illnesses for which psychosurgery is indicated.<sup>2</sup> There is a bias toward reporting positive results for this disorder, further complicating the evaluation of proposed treatment regimens. The one recurrent theme is that treatment modalities for depression are most likely to have benefit for these patients.

## Advances in Psychopharmacologic Treatment

The only medication to have controlled trials in OCD is clomipramine (Anafranil — Geigy).<sup>1,2</sup> This drug is not FDA approved but is widely available through compassionate use protocols and directly from Canada and Mexico. The Emory University Department of Psychiatry is currently conducting research with this medication, as are other hospitals and psychiatrists in Georgia. Clomipramine is technically a tricyclic antidepressant (TCA) that blocks reuptake of serotonin at the presynaptic neuronal membrane. Occasionally, pa-

tients experience an exacerbation of symptoms in the first week of treatment. Toxicity is reported to be low, chiefly the usual tricyclic side-effect profile.<sup>2-5</sup>

Similar anecdotal reports of positive response have been made with a variety of TCAs and non-TCAs. Monamine oxidase inhibitors (MAOIs) including phenelzine and tranylcypromine have many reports of benefit. Serotonergic TCAs such as amitriptyline and doxepin have been used with a variety of responses, mostly disappointing.<sup>6,7</sup> Yet imipramine has also had its successes where nonresponse was reported. Fluoxetine has had reports of benefit in OCD,<sup>8</sup> occasionally with dramatic responses prompting discussion on national television networks prior to marketing. Problems with dosage remain. Trazodone (Desyrel and others) is considered a standard first approach by many in this country. Zimelidine and fluvoxamine are considered first rank in world literature, but remain unavailable in clinical practice.<sup>1,2</sup>

Benzodiazepines are often used for these patients, although there are no good studies to demonstrate long-term success rates. Xanax has been reported to help patients with OCD and associated panic attacks. The size of the study was small without controls.<sup>2</sup>

Lithium has been given in conjunction with other antidepressants and alone. No consistent effect has been reported.<sup>2</sup>

Neuroleptics have been given to these patients, with minimal beneficial effects. Their potential long-term side effects make them far from a first-line drug choice. Perse has suggested that patients who are nonresponsive to TCAs and behavioral therapy be considered in a

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**The hallmarks of this illness include persistent, repetitive, and disturbing ideas and thoughts, images or ritualistic actions.**

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continuum between OCD and delusional psychosis. These may be patients for whom to consider neuroleptic treatment.<sup>1,2</sup>

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**The only medication to have controlled trials in OCD is clomipramine. Similar anecdotal reports of positive response have been made with a variety of TCAs and non-TCAs.**

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Other treatments have had occasional reports. Clonidine,<sup>4</sup> bromocriptine, amphetamines, carbamazepine, LSD, and others have anecdotal reports.<sup>1,2</sup> The number of treatments attempted indicate the misery these patients experience, and the frustration of the treating physician to find an elixir.

While an elixir to cure OCD appears unavailable, our current armamentarium is far more hopeful than in years past. Behavioral and environmental treatments have been the lone alternatives to medication, with very little success. Continuing research, controlled studies, and the cooperativeness of the FDA may help provide a global improvement in the lives of the 3 to 5% of Americans suffering from obsessive compulsive disorder.

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# Schizophrenia And Its Treatment

Philip T. Ninan, M.D.

**S**CHIZOPHRENIA is an illness caused by brain pathology (structural and/or functional) which results in abnormalities in thinking, emotions, and behavior. Between 1 and 2% of the U.S. population will experience an episode of schizophrenia in their lifetime.<sup>1</sup> This illness has a devastating effect on the individual, the family, and society. Over 100,000 psychiatric beds are occupied by schizophrenic patients, and their treatment costs are estimated at \$7 billion annually. Yet a large number of patients are still inadequately managed and swell the ranks of the homeless.

There is no single symptom that is pathognomonic for schizophrenia, or one that is universally present in all patients with the illness. This complicates the diagnosis, because various combinations of manifest and self-reported symptoms are used to ascertain the diagnosis. As our scientific knowledge advances, the diagnosis of schizophrenia will move from one based on manifest symptomatology to one based on pathophysiology.

This will allow the development of more specific and targeted treatments. In the meantime, we are restricted to the use of clinical symptoms in making the diagnosis of schizophrenia.

A basic requirement for a better understanding of schizophrenia is advances in nomenclature. With the introduction of the third edition of the American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM III) in 1980, diagnosis became based on a purely phenomenologic (i.e., descriptive) approach. For the diagnosis of schizophrenia, the DSM III required a specified list of psychotic symptoms for at least 6 months which started before the age of 45 and were associated with a deterioration in functioning. This removed theoretical and unproven etiologic considerations from the diagnostic criteria and provided for reliability in diagnostic classification. This was a

necessary step for the development of a valid diagnostic system that could be scientifically tested. The revised version of DSM III (DSM III-R) was published in 1987 and essentially removed the requirement that individuals have the onset of schizophrenic symptoms prior to the age of 45.<sup>2</sup>

The confirmation of the diagnosis by independent laboratory tests, however, is still lacking. Hence, validation of a clinical psychiatric diagnosis is limited. The course of the illness and response to treatment are thus taken as indirect indicators of the validity of the diagnostic label in schizophrenia. Therefore, apart from the specific psychotic symptoms that are a part of the diagnostic criteria of schizophrenia in the DSM III and DSM III-R, there must be deterioration from a previous level of functioning, and the symptoms must have been present for at least 6 months. Patients who have their psychotic symptoms last for less than 6 months are classified as having Schizophreniform Disorder, a label

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which implies (by definition) a better prognosis from schizophrenia.

### **Heterogeneity**

There is little doubt that schizophrenia is a simple clustering of symptoms that denote a syndrome or disorder much like pneumonia was a label in the pre-antibiotic era. Because each manifest symptom present in schizophrenia can be arrived at from different pathways, there are a number of etiologic and pathophysiologic mechanisms that can result in a particular symptom.

Thus, diagnosis based on phenomenology, although it is the best at this time, is still one step removed from an ideal diagnostic system that is based on etiology and pathophysiology. Our inability to subdivide schizophrenic patients into relevant biologic subgroups inherently limits our ability to predict clearly treatment response, outcome, and prognosis.

### **Genetics**

Family aggregation of the illness of schizophrenia has been clearly documented in a number of studies. However, the majority of patients do not have a first degree relative with the illness. Twin and adoption studies suggest that a vulnerability for the development of the illness is transmitted at a genetic level. The type of transmission is still debated. What is clear is that a classic Mendelian inheritance of a single dominant or a recessive gene is unlikely.<sup>3</sup>

Advances in molecular biologic techniques raise the intriguing possibility that markers close to the genes that are involved in the transmission of schizophrenia may be discovered in the near future.

### **Neuroimaging and Schizophrenia**

The last decade has seen a revolution in the neurosciences paralleled by breakthroughs in technology. Some of these advances have allowed us new visions into the brain. Early on, skull x-rays provided rudimentary information relevant to psychiatry. These were followed by CT scans which provided structural images in multiple cuts approaching a three dimensional format. Numerous CT studies in

schizophrenia were undertaken. The major finding was evidence of increased cerebral ventricular size and sulcal enlargement in some schizophrenic patients.<sup>4</sup> Magnetic resonance imaging (MRI) has improved on the resolution provided by CT without the hazards of exposure to radiation and has provided the possibility of images in multiple planes (transverse, coronal, and sagittal). Structural imaging, however, cannot provide insight into an illness that seems to have only non-specific structural changes and is predominantly an illness that results from functional anomalies.

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## **Advances in molecular biologic techniques raise the intriguing possibility that markers close to the genes that are involved in the transmission of schizophrenia may be discovered in the near future.**

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While it had been possible to look at brain functioning before, it was restricted to surface electrical activity or blood flow. The capacity to study deeper parts of the functioning brain has been a recent development. Functional imaging using SPECT and PET techniques allow studies of regional blood flow, glucose metabolism and measures of dopamine activity. Functional imaging studies are a quantum leap for psychiatry, just as echocardiograms and other functional measures of cardiac function were to cardiology.

Though functional imaging studies are still preliminary, and adequate replications are awaited, functional imaging data suggest that schizophrenic patients are not ac-

tivating their frontal lobes, especially when challenged with complex tasks that require a change in thinking strategies.<sup>5</sup> Schizophrenic patients (including ones never treated with neuroleptics) show evidence of increased dopamine activity in the caudate nucleus.<sup>6</sup>

### **Pharmacological Management**

Medications used in the treatment of schizophrenia have been called major tranquilizers, antipsychotic agents, and neuroleptics. The term "major" differentiates these tranquilizers from "minor" ones such as benzodiazepines, which also have sedating and calming effects but do not specifically have the capacity to treat symptoms of schizophrenia. Neuroleptic is a Greek derivative based on the neuromuscular side effects resulting from the extrapyramidal actions of the drug.

Neuroleptic agents have been shown to have antipsychotic effects that are not specific to schizophrenia. Not all schizophrenic patients respond to neuroleptic agents. Approximately 20% are unresponsive, and another 40% are only partially responsive. Furthermore, not all symptoms are equally responsive — the so-called "negative symptoms" (ie, relative lack of emotions, relatedness, and energy) are poorly responsive to pharmacologic intervention.

No neuroleptic agent generally available in the U.S. today has any greater therapeutic benefit compared to any other one. Thus, the choice is determined more on the basis of side effects. Major side effects include anticholinergic ones, postural hypotension, and extrapyramidal ones (acute dystonic reactions, pseudoparkinsonism, akathisia, and tardive dyskinesia). Less common but with considerable morbidity and mortality is neuroleptic malignant syndrome. This is a catastrophic reaction characterized by hyperthermia, severe muscle rigidity, and autonomic dysfunction. It is treated by immediate cessation of neuroleptics, bromocriptine, and dantrolene sodium.

The illness of schizophrenia is at times a continuous one, but more



frequently it is marked by episodes of symptom exacerbation followed by partial remission. Thus, neuroleptic agents have two indications in the treatment of schizophrenia: to control the symptoms of the acute episode and to provide maintenance and prophylaxis against the development of a subsequent episode. For the acute episode of schizophrenia, doses in the range of 400-600 mgs of chlorpromazine or equivalent are necessary.<sup>7</sup> Megadoses of neuroleptics (over 2000 mgs of Chlorpromazine or an equivalent) do not result in any greater or faster improvement in the symptoms. Combining benzodiazepines with neuroleptic agents in the early part of the treatment of an acute schizophrenic episode can be an appropriate strategy to induce sedation and control agitated behavior while using lower doses of neuroleptic agents. Extended use of benzodiazepines is discouraged, however, because of the risk of tolerance and dependence.

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### **Traditional psychodynamic therapies have not been effective in treating groups of schizophrenic patients, although individual patients have been helped.**

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Even with continued use of neuroleptics after an episode of schizophrenia, there is a 30% relapse within a year. Thus, prophylaxis is not absolute.

Maintenance and prophylactic strategies with neuroleptics aim to reduce the risk of side effects, especially long term and potentially irreversible ones, such as tardive dyskinesia. Neuroleptics also have the effect of sedating the patient into an amotivational state which impairs psychosocial functioning. Thus, the major thrust has been to

reduce the dose of neuroleptic used to minimal amounts or even to discontinue it completely once the acute episode has been controlled and the patient has returned to a previous level of functioning. These pharmacologic strategies depend on a close and frequent monitoring of the patient so that any early evidence of the return of an episode of illness can be met with a reinstatement of or increase in the medication. Compliance with treatment and availability of treatment staff are critical for such strategies to work effectively.

#### **Psychosocial Management**

Traditional psychodynamic therapies have not been effective in treating groups of schizophrenic patients, although individual patients have been helped. More recently, the focus on psychosocial management of schizophrenia has been in two areas: social skills training and family management. Both have been shown to have considerable impact on the course of illness.

Social skills training after recovery from an episode of schizophrenia has a positive impact on the social functioning of patients. It reduces the isolation and sense of hopelessness that is often the result of a psychotic episode. With time, such improvement in social functioning may be a step towards vocational functioning.

Family management strategies have moved away from older theories that believed families were the cause of the illness to recognizing that families are an important resource for the patient and provide an emotional milieu that can have an impact on the continued emotional health of schizophrenic patients. Family interactions that are characterized by hostility and emotional intrusiveness are associated with a higher rate of relapse in patients. Educating families about the illness, improving their problem solving and communication skills, expanding their social networks (using a cognitive/behavioral approach) have resulted in a significant reduction in relapse rates in patients.<sup>8</sup> Thus, once schizophrenia has developed, stressful envi-

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### **Functional imaging data suggests that schizophrenic patients are not activating their frontal lobes, especially when challenged with complex tasks that require a change in thinking strategies.**

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ronments have an impact on the outcome of the illness. Reducing the stressful environment around the patient has tremendous beneficial effects.

#### **Conclusion**

There have been significant advances recently in the phenomenology and classification of schizophrenia. Simultaneous advances in the neurosciences have led to a greater understanding of the neurobiology of schizophrenia. Treatment outcome studies, both in the pharmacologic and psychosocial areas, have led to improvements in treatment that are based on scientifically rigorous studies.

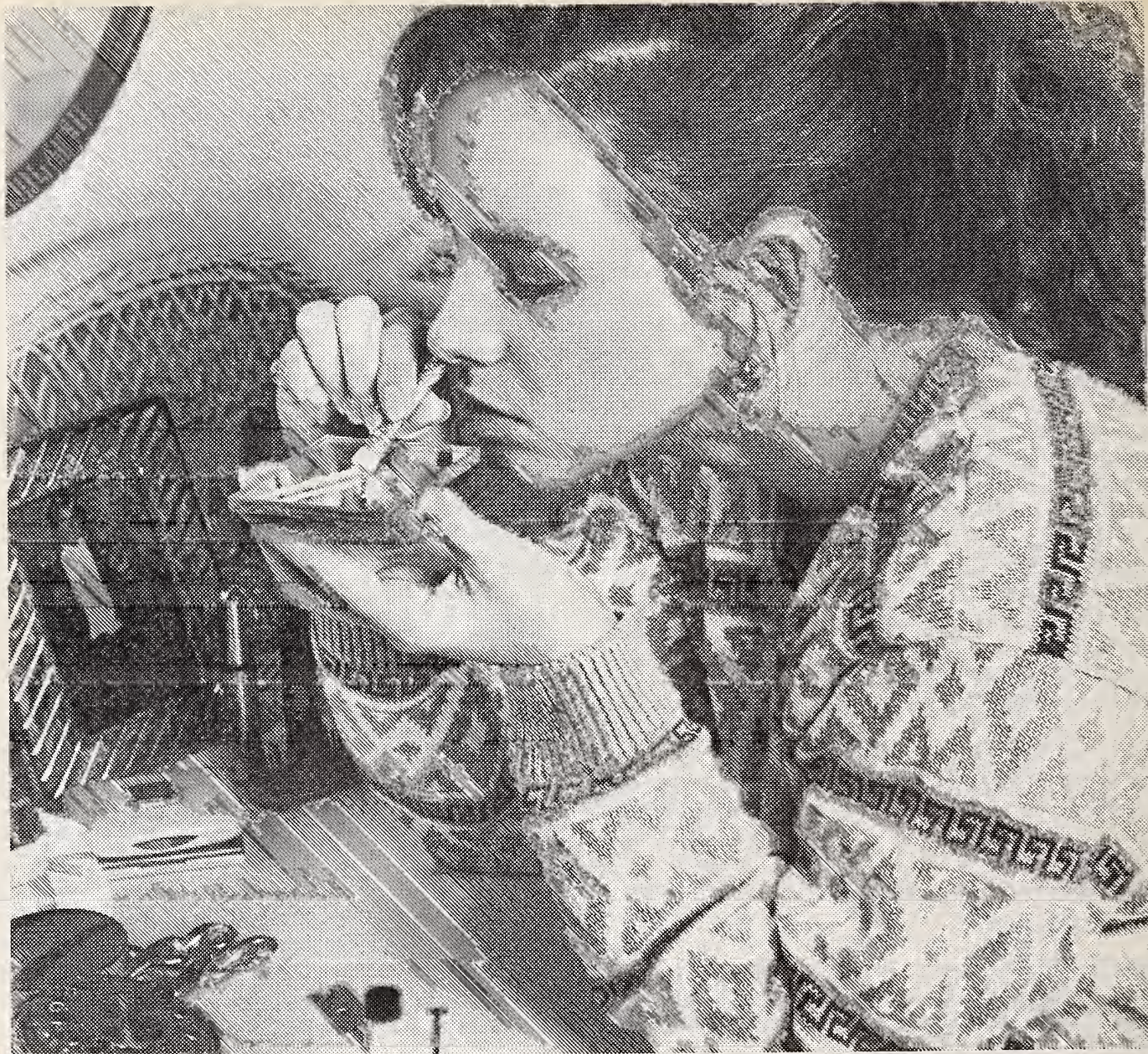
#### **Acknowledgements**

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# Update on the Treatment of Panic Attacks

Dave M. Davis, M.D., F.A.P.A.

**F**OUR TO SIX PERCENT of the population will experience at least one panic attack (anxiety attack, hyperventilation syndrome) sometime during their lives. In the past, treatment focused almost exclusively on exploring the psychodynamic or environmental causes of the illness, the hidden meanings of any associated phobias, and experiences of early separation anxiety. Desensitization and other behavior modification techniques were also used.

The most typical symptoms of panic attacks, listed in order of frequency are: sudden attacks of dizziness, panicky feeling, fidgetiness, tachycardia, sweating, shortness of breath, palpitations, hot flashes, trembling, derealization, fear of dying, depressed feeling, hyperventilation, faintness, and a feeling of "going crazy."

Agoraphobia is a common complication of panic attacks. The individual may develop an anticipatory fear of being helpless or losing control during a panic attack, so that they become reluctant to remain alone or go to public places away from home. Other common associated diseases in panic disorder are alcohol abuse, depressive



disorders, and misuse of anti-anxiety medications.

Medical work up should include studies for hyperthyroidism and careful history regarding the use of caffeine, diet pills, and other stimulant drugs. There may be a weak association between panic disorder and the presence of mitral valve

prolapse, but cardiology consultation is usually not a routine part of the evaluation.

## Treatment

The approach to panic disorder has changed dramatically with the introduction of specific psychopharmacologic therapies. Primary treatment strategy has switched to the use of psychotropic medications, including the tricyclic antidepressants, monoamine oxidase inhibitors, benzodiazepines, and the adjunctive use of supportive psychotherapy.

Tricyclics, particularly imipramine, have an excellent track record in blocking panic attacks and are the best choice for patients who have an concomitant history of depression. The usual course is to begin with a small dose, 25-50mgm daily, and increase this gradually, sometimes up to 200mgm daily, until a complete blockade of panic symptoms has been achieved. This often takes months. Some clinicians prefer to use desipramine (Norpramin) which is a metabolite of imipramine with markedly less anticholinergic side effects. Patients should be advised that for the first 10-14 days of tricyclic treat-

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ment, they may experience a slight worsening of the anxiety and panic. This effect usually passes as a down regulating effect on anxiety takes place.

Monoamine oxidase inhibitors, particularly phenelzine (Nardil), have been found to be very effective in the treatment and prevention of panic attacks. They seem to be particularly effective in those patients with a history of agoraphobia and/or family history of depression. Again, it is best to start with low doses and titrate the dose up over long periods of time. Dietary restrictions involving elimination of foods containing tyramine and drugs with pressor effects such as phenylpropanolamine and the narcotic, meperidine, are essential considerations and require extensive patient education.

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**Psychotropic medications used to treat and prevent panic attacks include the tricyclic antidepressants, monoamine oxidase inhibitors, and benzodiazepines.**

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Several of the high potency benzodiazepines, particularly lorazepam and clonazepam, have also been reported to be effective. Alprazolam in dose ranges of 3-8mg may be effective with the advantage of a quick onset and can block panic attacks within a week. Because of

alprazolam's short half life, it must be taken several times daily, and much care must be used in tapering off the drug, as otherwise patients will have rebound. Withdrawal seizures are also a possibility. Problems with dependency remain a concern with its long-term use.

It is often most feasible to start patients on both alprazolam and a tricyclic, slowly tapering alprazolam after several months of therapy. Since alprazolam may be habit forming, it is best to make an effort to eventually get patients off this drug if possible.

#### **Psychotherapy**

Supportive psychotherapy is directed toward teaching the patients that their attacks are not as dangerous as they seem and are ultimately harmless, unless they are driving a car or are in some other similar type of precarious situation. The attacks are self-limiting, and much reassurance is needed to convince that patient that they will not go crazy, or act out in some strange way, as they often fear. This will take time.

Additionally, since patients often associate certain places and particular situations (such as driving) with their panic attacks, efforts must be made by the therapist to have the patient slowly begin to return to the phobic geographic locations. This is most easily done after the panic attacks have been blocked for a period of time and the patient feels "safe."

While behaviorally oriented treatments may be a part of the treatment plan, combination treatment with medication is far more successful. It is inadvisable to refer patients with panic disorder to therapists providing *only* behavioral

modalities, although behavioral techniques may be helpful adjunctively. Panic disorder is a serious disease which often progresses. All such patients should have a careful evaluation by a psychiatrist with expertise in its psychopharmacologic treatment.

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**Panic disorder is a serious disease which often progresses. All such patients should have a careful evaluation by a psychiatrist with expertise in its psychopharmacologic treatment.**

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Fifteen years ago, the prognosis for panic disorder was poor due to poor recognition of the disorder and limited treatment options. Today, the outlook is extremely bright, and with appropriate treatment, 90-95% of patients can be successfully treated.

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# Assessment and Management of Suicidal Patients

Lucy Davidson, M.D., Ed.S.

**A**SSESSING A POTENTIALLY suicidal patient is one of the most worrisome tasks the physician faces. One's goal is to detect imminently lethal patients and protect them from self-harm while appropriate treatment is given. Although many persons who commit suicide visit a doctor shortly before they die, few identify their problem as suicidal ideation.<sup>1</sup> Instead, they may feel run down or complain of headaches, muscle spasms, indigestion, premenstrual syndrome, stress, etc. Moreover, not all persons thinking of suicide could be hospitalized for further evaluation. These potentially suicidal patients alone would fill every medical, surgical, and psychiatric hospital bed. The physician, then, must decide how likely the patient with suicidal ideation is to enact his or her self-destructive impulses. These considerations, as well as the diagnosis of underlying psychologic problems, determine the treatment mode and setting.

## Patient Assessment

Data on empiric risk factors for suicide can sharpen one's sensitivity in assessment.<sup>2,3</sup> The proportion of males to females committing suicide is approximately three to one, while that of attempters is reversed.

Suicide among males peaks during the young adult years and in old age. Women are more likely to commit suicide in late middle age. Suicide is more common among widowed and divorced people than among those single or married. In the United States, suicide is much more prevalent among whites than blacks. The incidence of suicide peaks in the spring and fall, not during the Christmas holidays as is popularly assumed. Depression, schizophrenia, and alcohol abuse are the most frequent psychiatric diagnoses among suicides. Persons who have previously attempted suicide are at increased risk for completed suicide. Absence of these risk factors certainly doesn't confer immunity to suicide, but their presence should raise one's index of suspicion.

The individual patient's vulnerability to suicide can only be determined by asking. Most suicidal patients are relieved by the opportunity to confide in a nonjudgmental physician. Tragically, we may shy away

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from asking the obvious of persons with whom we identify or are otherwise emotionally invested, such as fellow physicians and health care professionals, spouses and children of friends, and patients of long standing. Proceeding empathically from the more general query, "How bad do you feel?", to specific inquiries about hopelessness, wishing to be dead, wishing to harm oneself, and details of suicide plans or opportunities allows the physician to collect a wide range of information in assessing suicidal potential.<sup>4</sup> Until the physician is convinced that the patient is not immediately suicidal, the patient should not be left alone, even momentarily.<sup>5</sup>

### Decisions Regarding Hospitalization

The physician should weigh the information obtained in deciding whether the patient can be treated outside the hospital. Vulnerability to suicide increases with any significant loss (tangible or intangible, actual or threatened). Ongoing recovery from a major depression and the recent suicide of an acquaintance are situational factors that also increase the risk of suicide. Signs of impending suicide including giving away cherished possessions or pets, saying last goodbyes, rehearsing fatal behaviors, and equipping oneself for the preferred means of suicide.<sup>6</sup> Ominous factors are proximal substance abuse, active psychosis, and ready access to immediately lethal methods of suicide, e.g., a gun.

Favorable indications for outpatient management are past and current evidence of impulse control and the ability to establish rapport with the interviewer. Absence of a specific suicide plan with readily available means, along with the absence of psychosis and intoxication, is critical. Social supports are invaluable. Interviewing family members and significant others not only provides information that the patient may have suppressed or misperceived but also gives the physician a chance to assess the degree to which these people might help the patient. Willing family and friends can transport patients to ap-

pointments, store and administer medications, remove dangerous materials from the household, and provide emotional support to bridge times of hopelessness and apathy.<sup>7</sup>

If the suicidal patient can be managed outside the hospital, the physician must make definite arrangements for follow up. Giving the patient several names of psychiatrists or the community mental health center's phone number is ineffectual. Whenever possible, referral appointments should be set before the patient leaves. Telephoning patients to check on the arrangements made increases the likelihood of their following through with treatment.

Suicide attempters whose physical injuries do not mandate hospital admission are a difficult group of patients to evaluate. Surviving attempters are often embarrassed and may deny any suicidal intent in even the most blatantly self-destructive behaviors.<sup>8</sup> Their post hoc rationalizations may lead the physician to mistakenly trivialize the attempt and overlook serious suicidal potential. A period of psychiatric hospitalization may be warranted 1) to allow a more thorough evaluation when the effects of alcohol or other psychotropic substances have dissipated, 2) to allow time to meet with and assess information from family members and significant others, and 3) to allow time to explore the psychodynamic meaning of the patient's actions. The suicide attempter may have been in some form of psychotherapy. Psychiatric hospitalization provides an opportunity to reassess ongoing treatment and restructure it or provide therapeutic alternatives.

Suicidal behavior is an extreme expression of underlying psychopathology, not a diagnosis in itself. Thus, caring for suicidal patients implies stabilizing the underlying psychologic disorder as rapidly as possible. Affective disorders are frequent harbingers of suicide, yet many patients are unaware that depression is a treatable illness. Symptoms of depression are often viewed as willful pretence or character weakness. Time spent educating the patient and family ameliorates hopelessness and guilt.

### Pharmacologic Treatment

Paradoxically, effective pharmacotherapy of depression involves medications, such as tricyclic antidepressants, that are lethal in relatively small overdoses. In fact, amitriptyline is the most frequently used medication in suicide by overdose.<sup>9</sup> Yet, small, homeopathic doses of tricyclics or nonspecific treatment with various sedative-hypnotics and anxiolytics increase the risk of suicide by pharmacologically ignoring the patient's depression. Limiting the prescription size rather than the dose of antidepressants is key. Prescriptions for suicidal patients should be limited to 1200 mg total and be nonrefillable. Frequent office visits should be scheduled to assess patient response and suicidal potential. When outpatient pharmacotherapy poses an excessive risk of lethal overdose, out patient electroconvulsive therapy is an option.<sup>7</sup>

### Summary

Even intensely suicidal patients are ambivalent about killing themselves. Our efforts to assess and manage these patients recognize that the potential for suicide is a situational dynamic. During times of high lethality, environmental controls and constant, one-to-one nursing are prerequisites for aggressive diagnosis and treatment of underlying psychiatric disorders.

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## The New Informed Consent Law

Richard L. Greene

**T**HIS ARTICLE is part of MAG's continuing effort to inform member physicians about the new legal requirements of Informed Consent. Copies of the new Georgia statute on Informed Consent (O.C.G.A. 31-9-6.1) as well as the new Rules of the Composite State Board of Medical Examiners, Chapter 360-10, Patient Services to which this article refers can be obtained by contacting the author at MAG or by contacting MAG Mutual. The Rules have attached to them as Exhibit "A" and "B" Consent Forms that can be used by physicians. Those forms are printed at the conclusion of this article in a "modified" format. The modified version includes extra consent paragraphs that are helpful to the physician and informative to the patient. Also, procedure-specific forms are being developed that will also help physicians. Additionally, another optional form is included as Exhibit "C" which can be used as an alternative form when a procedure-specific form is not available. More details are provided in this article. MAG, MAG Mutual Insurance Company, and other groups are actively pursuing an aggressive education program to help physicians comply with this new statute when it becomes effective on January 1, 1989.

Mr. Greene is MAG's General Counsel. For further information about the new Statute and Rules, as well as copies of each, contact him at 938 Peachtree St., Atlanta, GA 30309; 800-282-0224.

### When Do You Provide "Informed Consent"?

Georgia is the last state to have a specific informed consent law. Unlike some other states, Georgia's new statute does not cover each and every procedure (even though some of the proponents attempted that for Georgia). Statutory "informed consent" is required only for the following patients:

- "(1) any person who undergoes any surgical procedure under (a) general anesthesia, (b) spinal anesthesia, or (c) major regional anesthesia." ["Major Region" is defined by Rule as an "entire arm, leg, torso, or any combination thereof." "Major regional anesthesia" means a state of insensitivity to pain affecting a major region of the body which is produced by the temporary interruption of the sensory nerve conductivity of such a region through the administration of a spinal, epidural, intravenous regional, or brachial plexus anesthetic. Rule 360-14-.02 (7) and (8)], or
- (2) any person who undergoes an amniocentesis diagnostic procedure, or
- (3) any person who undergoes a diagnostic procedure which involves the intravenous injection of a contrast material. ["Contrast material" means a non-physiologically occurring molecular compound used to produce density differences in tissues, organs, or vessels to permit visualization or imaging

of such internal bodily structures. Rule 360-14-.02(1)].

There are exceptions to the above situations where informed consent is not required to be given. (O.C.G.A. 31-9-6.1 (e) and Rule 360-14-.06). The three major exceptions are (1) emergencies, (2) a procedure that does not involve a material risk to the patient (generally recognized as such by reasonably prudent physicians), and (3) procedures that were unforeseen or not known to be needed at the time consent was obtained for another procedure *and* the patient has consented to allow the physician to make the decision concerning conducting the "unforeseen" procedure. A fourth exception is when the patient signs a "waiver" stating that he or she does not wish to be told all of the information. An example is found at the end of this article as Exhibit B.

The law further provides that the informed consent is to be obtained no more than 10 days prior to the procedure and is valid for up to 30 days from the date of admission if in conjunction with a hospitalization or for the period of confinement, whichever is greater.

### What Is MAG Doing To Help You?

MAG and the affected specialty societies are working to draft procedure-specific forms for commonly covered procedures. These forms should be a valuable asset to help physicians in their practice. These forms would not



only comply with the minimal statutory and Composite Board requirements, they would also take the next step by providing additional information beyond legal minimums.

The "procedure-specific" forms will include additional information such as other risks of the procedure and specific alternatives to the procedure. These forms will be available from MAG and the specialty societies once they develop the medical information. These forms are based on the minimal form established by the Composite Board and have been simplified and made more readable for patients. Use of these specialty society-developed forms should also be of significant benefit to physicians, as they will simplify compliance.

MAG and MAG Mutual are jointly sponsoring educational seminars throughout Georgia to educate physicians about informed consent. These seminars are designed to have an attorney moderate the presentation so that your individual questions can be answered. Both MAG Mutual and MAG also have staff attorneys available to assist you.

### Who Must Tell The Patient?

This new statute states that the "responsible physician" is liable if the required information is not given. The law does not require the physician to give the information, but it is the physician who is ultimately responsible to make sure it has

been provided. The responsible physician is defined [O.C.G.A. 31-9-6.1] (b) and Rule 360-2-.09 (13)] as the physician who "performs the procedure or the physician under whose direct orders the procedure is performed by a non-physician." The information can be disclosed through the use of video tapes, audio tapes, pamphlets, booklets, or other means of communication or through conversations with nurses, physician's assistants, trained counselors, patient educators, or other similar persons known to be knowledgeable and capable of communicating such information. So it is clear that persons other than physicians can provide the information, but it is important to know that if an employee of a hospital or ambulatory surgical treatment center participates in any such conversations, that employee (for the purpose of this law) is considered to be solely the agent of the "responsible physician."

### What Must You Tell the Patient?

A person undergoing the procedure outlined above must be "informed" in general terms of *each* of the following:

- (1) The patient's diagnosis requiring the procedure;
- (2) The nature and purpose of the procedure;
- (3) The *material risks* of the procedure;
- (4) The likelihood of success of the procedure;
- (5) The *practical alternatives* to

the procedure; and

- (6) The patient's prognosis if the procedure is refused.

The two most troublesome of these requirements for physicians are "material risks" and "practical alternatives." A material risk is explained [O.C.G.A. 31-9-6.1 (a) (3) and Rule 360-14-.02 (10)] as follows:

*"The material risks generally recognized and accepted by reasonably prudent physicians of infection, allergic reaction, severe loss of blood, loss or loss of function of any limb or organ, paralysis or partial paralysis, paraplegia or quadriplegia, disfiguring scar, brain damage, cardiac arrest, or death which could result from the major surgical or diagnostic procedure and which, if disclosed to a reasonably prudent person in the patient's position, could reasonably be expected to cause such prudent person to decline the major surgical or diagnostic procedure on the basis of material risk or injury that could result from the major surgical or diagnostic procedure."*

This means that if a physician performs a procedure covered by the statute, the patient should be told of the risks listed in the statute starting with infection and ending with death. It is *not* mandated that a physician give each of those risks with each procedure. A physician can leave out one or more of those listed risks if it is not a risk of that procedure "generally recognized

and accepted by reasonable prudent physicians." **However, the safer course is to give the entire list.**

It is obvious that the statutory list of "material risks" does not cover every risk of a specific procedure; likewise, the law does not necessarily mandate the disclosure of other risks of a particular procedure. However, it is good risk management and good patient relations to discuss in detail those additional risks. Physicians are encouraged to do more than the law requires concerning informed consent.

The requirement that *practical alternatives* be disclosed can create some problems. The law fortunately does not require the disclosure of every alternative, but rather only those "practical alternatives" which are "generally recognized and accepted by reasonably prudent physicians".

## The Form: Evidence of Informed Consent

The statute establishes the requirement of informed consent, but leaves considerable latitude with the physician as to how it is provided to the patient. As discussed earlier, the information can be provided by various means from the doctor, nurses, trained personnel, video tapes, pamphlets, etc. The law also allows the information to be given either orally or in writing. The safer method is a written document supplemented by adequate discussion with the patient. As you read the Composite State Board of Medical Examiner's form, you will realize that it does not give the patient all of the required information, but rather it is written *evidence* that the information has been given and that the patient has been given ample opportunity to ask questions about the procedure. A physician should not rely merely on the form but should provide additional information as well. Please note in the forms found

at the end of this article that some additional paragraphs have been added to the minimal Composite Board consent form as indicated by asterisks and are printed in italics. MAG and MAG Mutual Insurance Company recommend that these additional paragraphs be included in any forms that a physician uses. They are not necessarily required by the statute but will be helpful to the physician in defending a lawsuit.

Both MAG and MAG Mutual suggest using the procedure-specific form whenever possible. When it is not available, the physician has two alternative forms to choose from. One alternative form is Exhibit "C" at the end of this article. This form requires the physician to "fill in the blanks." If carefully completed for each patient, this will be an effective tool in decreasing malpractice lawsuits because it requires considerable direct physician-patient communication. The other alternative is the modified Composite Board form (Exhibit A) supplemented with the statutorily required information. The modified Composite Board form does not have a lot of blank spaces to be filled in on the document itself, but the information, such as alternative procedures, must be given to the patient and documented in the record. Case notes, pamphlets, brochures, and video tapes are examples of such documentation.

This information should be carefully and completely documented in the patient's record. If possible, another person should witness you providing the information.

## Informed Consent Lawsuits

The responsible physician's failure to ensure that the information is provided may lead to a medical malpractice lawsuit. Georgia's physicians were protected from a lawsuit merely because the required information

was not given. In order to bring an action against the responsible physician, the law requires in subparagraph (d) that the plaintiff show: (1) that the patient suffered an injury caused by the procedure; (2) that the required information was not disclosed; and (3) that "a reasonably prudent patient would have refused the surgical or diagnostic procedure or would have chosen a practical alternative to such proposed surgical or diagnostic procedure if such information had been disclosed." [O.C.G.A. 31-9-6.1(d)]. The law even goes further in protecting physicians by requiring that a lawsuit be an action for "medical malpractice" which includes the filing of an affidavit by an expert along with the suit. The expert's affidavit must state that (1) the patient suffered an injury caused by the procedure and (2) that such injury was a material risk required to be disclosed by the new law. This obviously gives extra protection to the physician. Making it a medical malpractice action gives physicians the protection provided by tort reform and stops plaintiff's lawyers for bringing two separate lawsuits, one for medical malpractice and a separate suit for ordinary negligence for failure to inform the patient or even a battery action.

## Conclusion

The new Informed Consent Act will clearly impact the method of practice for many physicians in Georgia. You are urged to contact MAG for a copy of the Statute and Rules and to familiarize yourself with both. New legal responsibilities are being added, but the statute can also act as a shield providing protection because for the first time specific guidelines are being given to the physician. **There are statutory protections for physicians within the statute.** Only time and litigation will give us the answers to all of our questions.



## “Exhibit A”

### Consent to Surgical or Diagnostic Procedures

DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS

Name of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

(A)(1) I acknowledge and understand that the following procedures which have been described to me are to be performed on the patient:

and that as a result of the performance of the procedures there is a material risk that the patient may suffer INFECTION, ALLERGIC REACTION, SEVERE LOSS OF BLOOD, LOSS OR LOSS OF FUNCTION OF ANY LIMB OR ORGAN, PARALYSIS OR PARTIAL PARALYSIS, PARAPLEGIA OR QUADRAPLEGIA, DISFIGURING SCAR, BRAIN DAMAGE, CARDIAC ARREST, OR DEATH.

(2) I acknowledge and understand that during the course of the procedures described in paragraph (A), conditions may develop which may reasonably necessitate an extension of the original procedures or the performance of procedures which are unforeseen or not known to be needed at the time this consent is obtained. I therefore consent to and authorize the persons described in the last paragraph of this consent to make the decisions concerning the performance of and to perform such procedures as they may deem reasonably necessary or desirable in the exercise of their professional judgment, including those procedures that may be unforeseen or not known to be needed at the time this consent is obtained. This consent shall also extend to the treatment of all conditions which may arise during the course of such procedures including those conditions which may be unknown or unforeseen at the time this consent is obtained.

(B) I acknowledge and understand and duly evidence in writing by executing this form that I have been informed in general terms of the following:

- (1) A diagnosis of the condition requiring the procedures;
- (2) The nature and purpose of the procedures;
- (3) The material risks of the procedures (see paragraph (A) above);
- (4) The likelihood of success of the procedures;
- (5) The practical alternatives to such procedures; and
- (6) The prognosis if the procedures are rejected;

and that such was provided through the use of video tapes, audio tapes, pamphlets, booklets, or other means of communication or through conversations with the responsible physician, or other medical personnel under the supervision and control of the responsible physician, other medical personnel involved in the course of treatment, nurses, physician's assistants, trained counselors, or patient educators.

*\*\* (C) I acknowledge and understand that in addition to the material risks of the procedures listed in paragraph (A) above there may be other risks attendant to the performance of the procedures as there are with any surgical or diagnostic procedure.*

*\*\* (D) I acknowledge that there are practical alternatives to the procedures described in paragraph (A) which alternatives reasonably prudent physicians generally recognize and accept.*

*\*\* (E) I acknowledge and understand that the physician, medical personnel, and other assistants will rely on the patient's statements, medical history, and other information provided by the patient in determining whether to perform the procedures or the course of treatment for the patient's condition and in recommending the procedures which have been explained.*

*\*\* (F) I acknowledge and understand that the practice of medicine is not an exact science, and I acknowledge that NO GUARANTEES HAVE BEEN MADE TO ME concerning the results of the procedures.*

*\*\* (G) I also consent to diagnostic studies, tests, anesthesia, x-ray examinations, and any other treatment or courses of treatment relating to the procedures described in paragraph (A) which may be prescribed or ordered.*

*\*\* (H) I also consent that any tissues, specimens, members, etc. removed in the course of any procedure may be tested, retained, or preserved for scientific or teaching purposes and then disposed of within the discretion of the physician, facility, or other health care provider.*

*\*\* (I) I acknowledge and understand that this request for and consent to surgical or diagnostic services shall be valid for the responsible physician, all medical personnel under the direct supervision and control of the responsible physician, and for all other medical personnel otherwise involved in the course of treatment.*

I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND ANY QUESTIONS I HAVE ASKED HAVE BEEN ANSWERED OR EXPLAINED IN A SATISFACTORY MANNER. *\*\* ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN AND ALL STATEMENTS I DO NOT APPROVE OF WERE STRICKEN BEFORE I SIGNED THIS FORM. I ALSO HAVE RECEIVED ADDITIONAL INFORMATION, INCLUDING BUT NOT LIMITED TO THE MATERIALS LISTED BELOW, RELATING TO THE PROCEDURES DESCRIBED HEREIN.*

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE READ OR HAD IT READ OR EXPLAINED TO ME AND I UNDERSTAND THIS FORM AND I VOLUNTARILY CONSENT TO ALLOW DR. \_\_\_\_\_

OR ANY PHYSICIAN DESIGNATED OR SELECTED BY HIM OR HER AND ALL MEDICAL PERSONNEL UNDER THE DIRECT SUPERVISION AND CONTROL OF SUCH PHYSICIAN AND ALL OTHER PERSONNEL WHICH MAY OTHERWISE BE INVOLVED IN PERFORMING SUCH PROCEDURES TO PERFORM THE PROCEDURES DESCRIBED OR OTHERWISE REFERRED TO HEREIN.

WITNESS \_\_\_\_\_

Signature of patient or other person authorized to sign \_\_\_\_\_

Additional materials used, if any, during the informed consent process for this procedure include: \_\_\_\_\_

Person giving consent \_\_\_\_\_

*\*\* Portions indicated with asterisks and in italics are those which have been added by MAG to the original CSBME consent form. Physicians are urged to use this expanded form when using the CSBME version.*

## “Exhibit B”

Consent to Surgical or Diagnostic Procedures and Waiver of Right to Receive Information in Connection Therewith  
DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS.

Name of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

(A)(1) I acknowledge and understand that the following procedures which have been described to me are to be performed on the patient:

(2) I acknowledge and understand that during the course of the procedures described in paragraph (A), conditions may develop which may reasonably necessitate an extension of the original procedures or the performance of procedures which are unforeseen or not known to be needed at the time this consent is obtained. I therefore consent to and authorize the persons described in the last paragraph of this consent to make the decisions concerning the performance of and to perform such procedures as they may deem reasonably necessary or desirable in the exercise of their professional judgment, including those procedures that may be unforeseen or not known to be needed at the time this consent is obtained. This consent shall also extend to the treatment of all conditions which may arise during the course of such procedures including those conditions which may be unknown or unforeseen at the time this consent is obtained.

(B) I acknowledge and understand and duly evidence in writing by executing this form that under Georgia law I am entitled to receive the following information relative to the procedures described in paragraph (A):

- (1) A diagnosis of the condition requiring the procedures;
- (2) The nature and purpose of the procedures;
- (3) The material risks of the procedures;
- (4) The likelihood of success of the procedures;
- (5) The practical alternatives to such procedures; and
- (6) The prognosis if the procedures are rejected.

*\*\* (C) I acknowledge and understand that in addition to the material risks of the procedures there may be other risks attendant to the performance of the procedures as there are with any surgical or diagnostic procedure.*

*\*\* (D) I acknowledge that there are practical alternatives to the procedures described in paragraph (A) which alternatives reasonably prudent physicians generally recognize and accept.*

*\*\* (E) I acknowledge and understand that the physician, medical personnel, and other assistants will rely on the patient's statements, medical history, and other information provided by the patient in determining whether to perform the procedures or the course of treatment for the patient's condition and in recommending the procedures which have been explained.*

*\*\* (F) I acknowledge and understand that the practice of medicine is not an exact science and I acknowledge that NO GUARANTEES HAVE BEEN MADE TO ME concerning the results of the procedures.*

*\*\* (G) I also consent to diagnostic studies, tests, anesthesia, x-ray examinations, and any other treatment or courses of treatment relating to the procedures described in paragraph (A) which may be prescribed or ordered.*

*\*\* (H) I also consent that any tissues, specimens, members, etc. removed in the course of any procedure may be tested, retained, or preserved for scientific or teaching purposes and then disposed of within the discretion of the physician, facility, or other health care provider.*

*\*\* (I) I acknowledge and understand that this request for and consent to surgical or diagnostic services shall be valid for the responsible physician, all medical personnel under the direct supervision and control of the responsible physician, and for all other medical personnel otherwise involved in the course of treatment.*

I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND ANY QUESTIONS I HAVE ASKED HAVE BEEN ANSWERED OR EXPLAINED IN A SATISFACTORY MANNER. **\*\*ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN AND ALL STATEMENTS I DO NOT APPROVE OF WERE STRICKEN BEFORE I SIGNED THIS FORM.**

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE READ OR HAD IT READ OR EXPLAINED TO ME AND I UNDERSTAND THIS FORM AND I VOLUNTARILY CONSENT TO ALLOW DR. \_\_\_\_\_

OR ANY PHYSICIAN DESIGNATED OR SELECTED BY HIM OR HER AND ALL MEDICAL PERSONNEL UNDER THE DIRECT SUPERVISION AND CONTROL OF SUCH PHYSICIAN AND ALL OTHER PERSONNEL WHICH MAY OTHERWISE BE INVOLVED IN PERFORMING SUCH PROCEDURES TO PERFORM THE PROCEDURES DESCRIBED OR OTHERWISE REFERRED TO HEREIN AND I FULLY AND COMPLETELY WAIVE THE RIGHT TO BE INFORMED OF THE INFORMATION SPECIFIED IN PARAGRAPH (B) AND REQUEST THAT SUCH INFORMATION NOT BE DISCLOSED.

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
Signature of patient or other person authorized to sign

\*\*Portions indicated with asterisks and in italics are those which have been added by MAG to the original CSBME consent form. Physicians are urged to use this expanded form when using the CSBME version.



## “Exhibit C”

(ALTERNATIVE FORM FOR USE WHEN PROCEDURE SPECIFIC FORM IS NOT AVAILABLE)

REQUEST AND INFORMED CONSENT TO (PROCEDURE OR DIAGNOSTIC TEST)

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT AND FULLY UNDERSTAND ITS CONTENTS

PATIENT'S NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

The following has been explained to me in general terms and I understand that:

1) The diagnosis requiring this procedure is \_\_\_\_\_

(diagnosis described in layman's terms)

2) The nature of the procedure is \_\_\_\_\_

(describe procedure in layman's terms)

3) The purpose of this procedure is \_\_\_\_\_

(specific for this patient)

4) **MATERIAL RISKS OF THIS PROCEDURE:**

As a result of this procedure being performed there may be material risks of: INFECTION, ALLERGIC REACTION, DISFIGURING SCAR, SEVERE LOSS OF BLOOD, LOSS OR LOSS OF FUNCTION OF ANY LIMB OR ORGAN, PARALYSIS, PARAPLEGIA OR QUADRIPLÉGIA, BRAIN DAMAGE, CARDIAC ARREST OR DEATH.

5) In addition to these material risks, there may be other possible risks involved in this procedure including but not limited to: \_\_\_\_\_

6) The likelihood of success of the above procedure is:

( ) Good; ( ) Fair; ( ) Poor

7) Practical alternatives to this procedure include: \_\_\_\_\_

8) If I choose not to have the above procedure, my prognosis (future medical condition) is: \_\_\_\_\_

(to be filled in during informed consent process)

I understand that the physician, medical personnel and other assistants will rely on statements about the patient, the patient's medical history, and other information in determining whether to perform the procedure or the course of treatment for the patient's condition and in recommending the procedure which has been explained.

I understand that the practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME concerning the results of this procedure.

I understand that during the course of the procedure described above it may be necessary or appropriate to perform additional procedures which are unforeseen or not known to be needed at the time this consent is given. I consent to and authorize the persons described herein to make the decisions concerning such procedures. I also consent to and authorize the performance of such additional procedures as they deem necessary or appropriate.

I also consent to diagnostic studies, tests, anesthesia, x-ray examinations and any other treatment or courses of treatment relating to the diagnosis or procedures described herein.

I also consent that any tissues, specimens, organs or limbs removed from the patient's body in the course of any procedure may be tested or retained for scientific or teaching purposes and then disposed of within the discretion of the physician, facility or other health care provider.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ OR HAD THIS FORM READ AND/OR EXPLAINED TO ME, THAT I FULLY UNDERSTAND ITS CONTENTS, AND THAT I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND THAT ANY QUESTIONS HAVE BEEN ANSWERED SATISFACTORILY. ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN AND ALL STATEMENTS I DO NOT APPROVE OF WERE STRICKEN BEFORE I SIGNED THIS FORM. I ALSO HAVE RECEIVED ADDITIONAL INFORMATION INCLUDING BUT NOT LIMITED TO THE MATERIALS LISTED BELOW RELATING TO THE PROCEDURES DESCRIBED HEREIN.

I voluntarily consent to allow Dr. \_\_\_\_\_ or any physician designated or selected by him or her and all medical personnel under the direct supervision and control of such physician and all other personnel who may otherwise be involved in performing such procedures to perform the procedures described or otherwise referred to herein.

Witness \_\_\_\_\_

Person giving consent \_\_\_\_\_

Relationship to patient if not the patient \_\_\_\_\_

Patient unable to sign because of \_\_\_\_\_

Additional materials used, if any, during the informed consent process for this procedure include: \_\_\_\_\_

Person giving consent \_\_\_\_\_

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**Contraindication:** Known allergy to cephalosporins.

**Warnings:** CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

**Precautions:**

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in

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- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

**Adverse Reactions:** (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
  - As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
  - Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
  - Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%, and, rarely, thrombocytopenia.
- Abnormalities in laboratory results of uncertain etiology**
- Slight elevations in hepatic enzymes.
  - Transient fluctuations in leukocyte count (especially in infants and children).
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## Well-Differentiated Thyroid Neoplasia: A Curable Cancer

Charles M. Ferguson, M.D., F.A.C.S.

### Introduction

**W**ELL-DIFFERENTIATED thyroid neoplasms are the most common neoplasms of the thyroid gland and are imminently curable. In the Third National Cancer Survey, performed from 1969 to 1971, the prevalence of thyroid cancer was found to be 3.7 per 100,000.<sup>1</sup> In autopsy studies, careful examination of the thyroid reveals occult malignancy in 13 to 30%.<sup>2,3</sup> This discrepancy of pathologically determined and clinically apparent carcinoma points out the relatively innocent nature of many of these tumors. The biologic behavior of these tumors, however, is variable, and while growth of these tumors is rather indolent, some may cause death. Fortunately, the prognosis of these tumors can be predicted to some extent by the clinical and pathologic features of the individual patient. Thus, management decisions can be made on the basis of these findings.

Because of the slow growth rate of these tumors, recurrence and net mortality are low. Extremely long follow up (up to 20 years or more) is necessary to determine differences in outcome based on different management. In addition, no prospective trials comparing various therapies exist. Thus, considerable controversy exists regarding extent of surgery and the addition of adjuvant

**“There is no consensus as to the extent of surgery for thyroid. At the minimum, the thyroid lobe containing the cancer plus the isthmus and any enlarged nodes should be removed.”**

therapy. This paper will attempt to outline some of these controversies and present a compromise plan of management that can be used in the management of these tumors.

### Pathology

Pathologically, well-differentiated thyroid neoplasms are categorized as papillary and follicular. Papillary carcinoma is the more common and has a peak incidence in the third and fourth decades. Papillary carcinoma may vary in size from small incidental lesions to large tumors invading contiguous structures. Multicentricity and bilaterality of these tumors is frequent, occurring in 20 to 80% of cases, depending mainly on the diligence with which the thyroid gland is pathologically

examined.<sup>4,5</sup> Papillary carcinoma has a marked propensity to lymphatic invasion, which may be found in up to 90% of carefully examined lymph nodes.<sup>6</sup> Occasionally, aggressive anaplastic carcinoma may arise within a well-differentiated papillary carcinoma.<sup>7,8</sup> This appears to be an inherent characteristic of the particular papillary carcinoma rather than a consequence of therapy.<sup>9</sup>

Follicular carcinoma accounts for about 15% of thyroid cancers in the United States.<sup>10</sup> Microscopically, these tumors are highly cellular and composed of multiple, tightly packed, small follicles. Aggressive behavior of the tumor is indicated by vascular invasion, invasion of the tumor capsule, and distant metastasis. Because of difficulty in examining the entire tumor capsule, diagnosis of follicular carcinoma by frozen section is unreliable.<sup>11</sup> Lymphatic invasion by follicular carcinoma is rare, but metastasis to the lung, brain, and bone occur with greater frequency than with papillary carcinoma. Also, unlike papillary carcinoma, tiny primary tumors can metastasize.<sup>12</sup>

### Treatment

#### Surgery

Primary therapy of well-differentiated thyroid neoplasms is surgical. Considerable controversy exists concerning the amount of surgery to be

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performed. There is no general agreement among surgeons as to what surgery is best. Commonly accepted alternatives include total or near total thyroidectomy or total lobectomy on the side of the neoplasm plus isthmectomy. In support of total thyroidectomy is that contralateral microscopic foci of tumor are found in 30 to 80% of patients undergoing total thyroidectomy for tumors grossly confined to one lobe.<sup>13-15</sup> However, the incidence of contralateral neck recurrence following lobectomy for papillary carcinoma in most series is only 5 to 10%.<sup>16-18</sup> Thus, some of these microscopic tumor foci must never become clinically significant, and the role of resection of microscopic tumor foci is unclear. Another argument in favor of total or near total thyroidectomy is the ease of subsequent diagnosis of recurrence by physical examination, serum thyroglobulin levels, and radioactive iodine scan. Finally, as mentioned previously, anaplastic carcinoma may arise from well-differentiated carcinoma and particularly with recurrence of a previous tumor.<sup>19, 20</sup> Any measure which would decrease recurrence should prevent this occurrence of anaplastic carcinoma.

Balanced against these theoretic advantages of total thyroidectomy are the lack of prospective data demonstrating a

clear survival advantage and the risk of increased complications. While most studies suggest decreased local recurrence and increased survival with total or near total thyroidectomy as compared to lobectomy and isthmectomy,<sup>18, 21, 22</sup> the studies are retrospective and there is some concern about the comparability of groups. Of note, Wang, et al,<sup>23</sup> recently reported no difference in survival between total thyroidectomy and lobectomy and isthmectomy for tumors grossly confined to the thyroid.

Removal of the thyroid potentially endangers the parathyroid glands and recurrent nerves. Total thyroidectomy in particular would be expected to carry significant risk of hypoparathyroidism. Rates as high as 15% have been reported.<sup>22</sup> With unilateral lobectomy, permanent hypoparathyroidism does not occur, since two of the parathyroid glands remain undisturbed. Near total thyroidectomy preserves a small rim of thyroid tissue from the lobe contralateral to the tumor to ensure a good blood supply to the parathyroid glands.

Permanent vocal cord paralysis is rare following thyroid surgery, but it is always a possibility. Following unilateral thyroid lobectomy, cord paralysis occurs in about 0.5 percent of operations, while with total thyroidectomy rates are in the

range of 1.6%.<sup>22, 24</sup> However, several investigators have recently reported rates of hypoparathyroidism and permanent cord paralysis with total or near total thyroidectomy equal to, or better than, those previously reported for unilateral lobectomy. It is clear that this is a safe operation in the hands of an experienced surgeon.<sup>14, 25-27</sup>

As noted previously, lymph node metastases are common in papillary carcinoma. At the time of thyroidectomy (of whichever type), any grossly involved nodes should be removed. Extensive lymph node dissection is not advocated, however, and formal neck dissection has not been found to be beneficial.<sup>21</sup>

From the above discussion, it should be clear that there is no consensus as to the extent of surgery for thyroid cancer. At a minimum, the thyroid lobe containing the cancer plus the isthmus and any enlarged nodes should be removed. Removal of the entire thyroid gland has theoretic advantages in terms of tumor control and makes follow up and subsequent treatment easier. It does, however, increase the risk of complications.

**Thyroid Suppression**

There is evidence to suggest that thyroid stimulating hormone (TSH) is a promoter or inducer of thyroid cancer, and that TSH suppression decreases recurrence

following thyroidectomy for carcinoma. In the experience of Mazzaferri, et al,<sup>21</sup> the recurrence rate is four-fold greater when patients are not given thyroid hormone postoperatively. It is generally accepted that all patients should receive postoperative thyroid hormone in a dose that suppresses TSH to low or undetectable levels that do not respond to TRH stimulation. Such an effect can be obtained in most adults with doses of l-thyroxin of 2.25 micrograms/kg.

## Radioactive Iodine

I-131 can be used to eliminate tissue which concentrates iodine. Thus, any thyroid remnant left after surgery or any micrometastases in cervical lymph nodes could be eliminated by the postoperative use of I-131. This treatment has been shown to decrease local recurrence and improve survival in selected patients, using age and sex-matched controls.<sup>21</sup> Side effects of treatment include nausea and occasional vomiting, leukopenia, and thrombocytopenia, with a nadir of 3 to 6 weeks. Rare

**TABLE 1 — National Thyroid Cancer Treatment Cooperative Group Risk Groups**

- |  |
|--|
| I) Minimal Risk (<5% excess 10-year mortality) age <45, papillary or follicular, <4 cm single nodule or microscopic multifocal or microscopic nodal metastasis |
| II) Low Risk (5%-20% excess 10-year mortality) <45, papillary or follicular, >4 cm, or gross multifocal, or capsular invasion, or macroscopic nodes            |
| III) Moderate Risk (20%-60% excess 10-year mortality) >45, papillary or follicular, >4 cm single nodule or gross extraglandular invasion                       |
| IV) High Risk (60%-100% excess 10-year mortality) papillary or follicular metastasis outside neck  |

**TABLE 2 — EORTC Prognostic Index**

Prognostic Index score obtained by:

Age at diagnosis

- + 12 for male sex
- + 10 for follicular or medullary histology
- + 45 for anaplastic histology
- + 10 for extra thyroid extension
- + 15 for one distant metastasis
- + 15 for multiple distant metastasis

Total score = \_\_\_\_\_

Score

<50  
50-65  
66-83  
84-108  
>109

5-year Survival (%)

95  
80  
51  
33  
5

complications include aplastic anemia, pulmonary fibrosis, leukemia, and prolonged leukopenia or thrombocytopenia.<sup>28</sup> Ablation of residual thyroid is usually done at 6 weeks after surgery, with the patient off T-4 for a minimum of 4 weeks and off T-3 for 2 weeks. Selection of patient for this therapy will be discussed subsequently.

## Selection of Therapy

In order to make decisions in therapy, some concept of risk of recurrence must be obtained. Factors correlated with increased mortality include increased age, increased size of primary tumor, presence of local invasion or metastasis, male sex, and follicular histology (mixed papillary-follicular histology carries the same prognosis as papillary.<sup>5, 28-30</sup> There is some controversy concerning each of these prognostic factors, most notably histology.<sup>31</sup> Several risk categorization schemes exist (Tables 1 and 2). These risk categorizations can be used to help select therapy. Most would agree that patients in NTCTCG Group One could be adequately

treated by surgery, be it lobectomy and isthmectomy or near total thyroidectomy, followed by thyroid suppression. The patients in groups two, three, and four should probably receive near total thyroidectomy, I-131, and thyroid suppression.

This is essentially the plan of management used at present at Grady Memorial Hospital in Atlanta. It should be emphasized that each patient's situation is evaluated individually, and recommendations are made on the basis of patient age, sex, tumor size and extent, and tumor histology. In general, we tend to perform near total thyroidectomy for clinically apparent thyroid carcinoma, and have had no incidence of permanent hypoparathyroidism or permanent vocal cord paralysis since the institution of this policy in 1984. Synthroid suppression is recommended to all patients.

## Results

Results of therapy with well-differentiated thyroid carcinoma are excellent. Results of nationwide studies show 5- and 10-year survivals of 95% and 95% respectively, in localized disease,



and 83% and 80% respectively, in regional disease.<sup>32</sup> In patients with regional disease treated with surgery, I-131, and TSH suppression, 10-year recurrence rates are less than 10% for papillary carcinoma and less than 5% for follicular carcinoma.<sup>21, 33</sup> When recurrences do develop, they can often be treated with I-131, resulting in excellent palliation and prolonged survival.

***“It is generally accepted that all patients should receive postoperative thyroid hormone in a dose that suppresses TSH to low or undetectable levels that do not respond to TRH stimulation.”***

In summary, well-differentiated thyroid carcinoma is easily curable in early stages. Even in advanced stage, well-differentiated thyroid carcinoma can be cured or at least have prolonged survival by using a combination of surgery, radioactive iodine ablation, and TSH suppression. This is an area of oncology where the multidisciplinary approach is truly effective.

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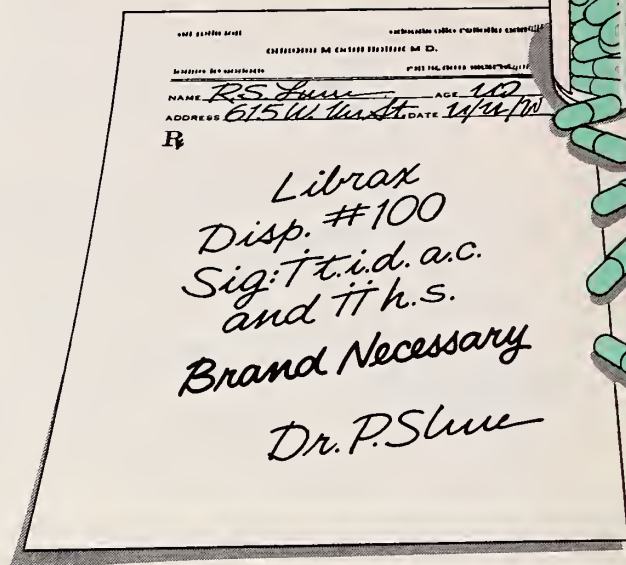


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**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.  
**Adverse Reactions:** No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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P.1 0288

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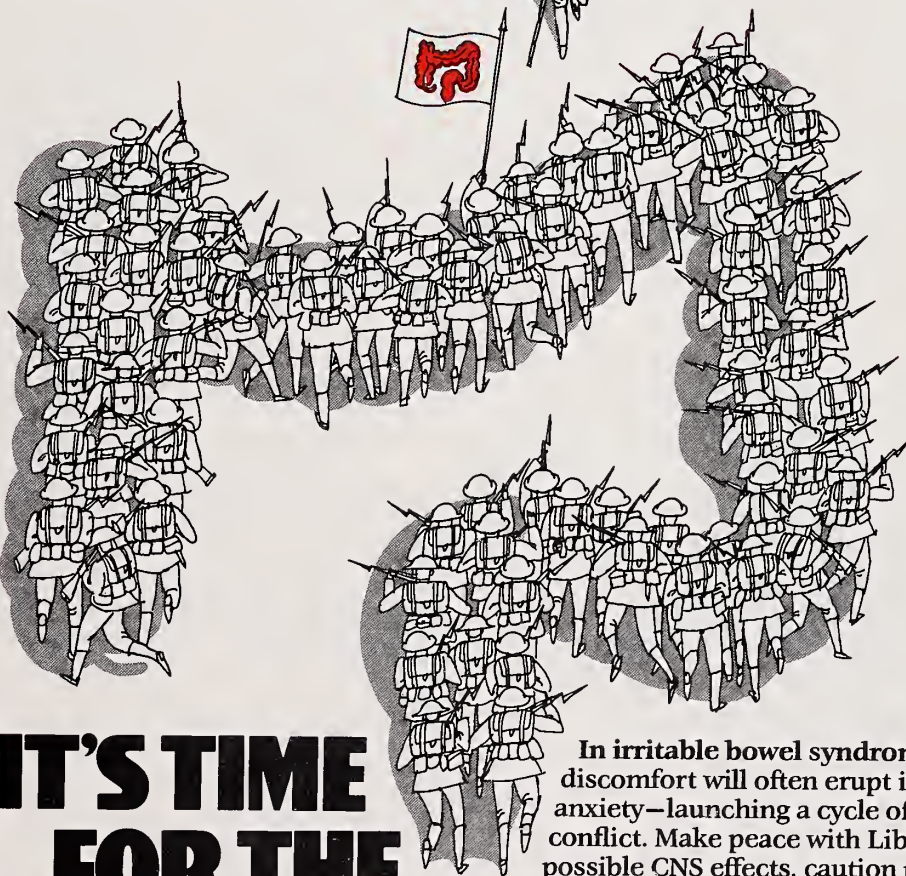
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DECEMBER 1988

# JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

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Season's  
Greetings

A decorative arrangement of colorful streamers and bows is positioned vertically on the cover. The bows are made of various colored ribbons (red, green, yellow, orange, purple, blue) and are connected by long, flowing white streamers that create a vertical line down the center of the page.

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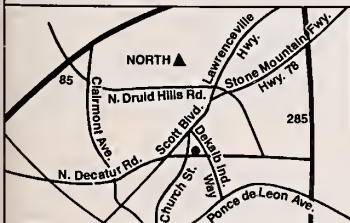
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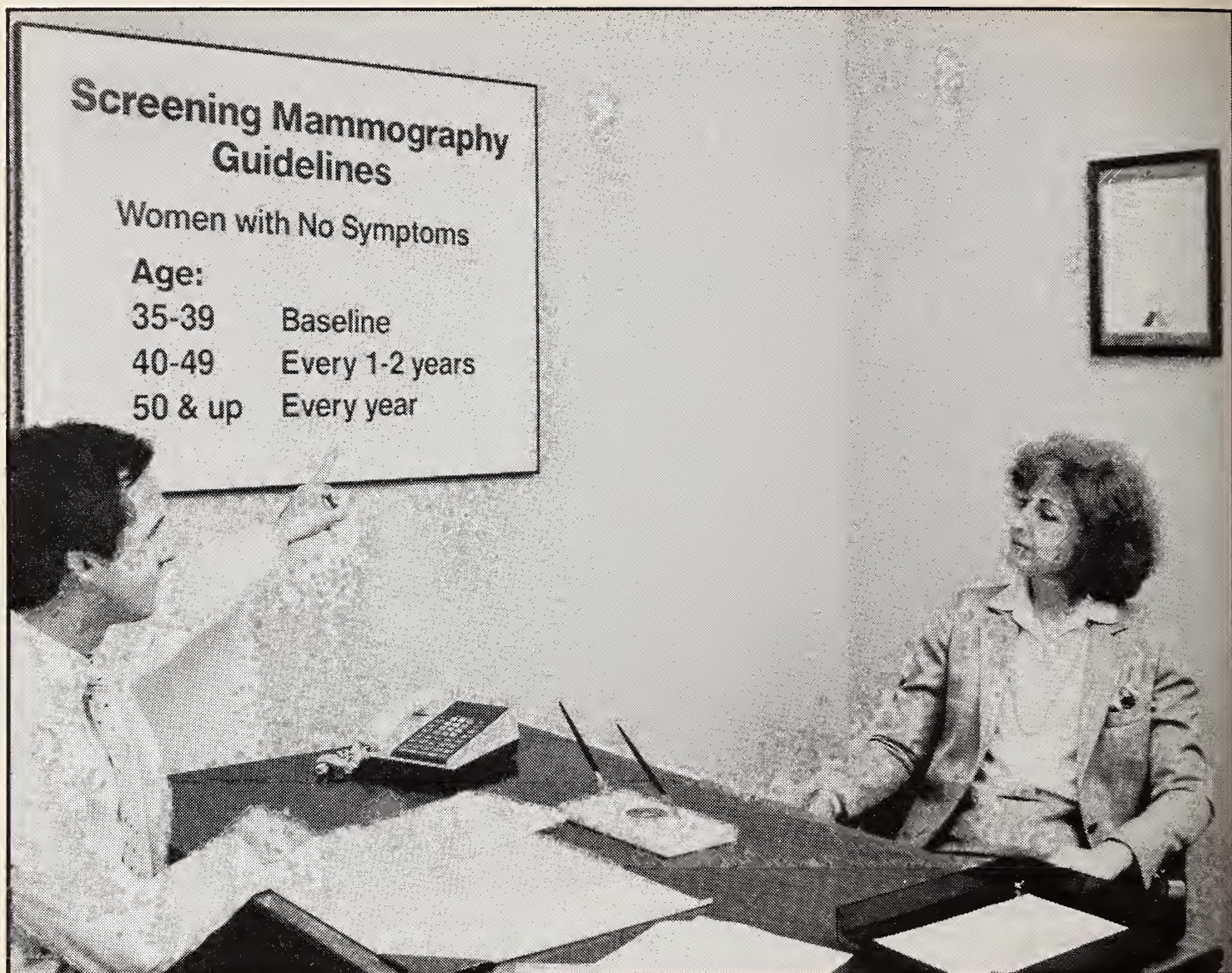
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THE COVER

The colorful, festive art of New York City artist Dorothy Gillespie is featured on this month's cover. Ms. Gillespie's work is handled exclusively in Atlanta by EVE MANNES GALLERY at Tula, 75 Bennett St., Suite 2B, Atlanta 30309; 404-351-6651. Page 867 offers more information about this well known artist.

Dear Editor,

**I** WOULD like to comment on the article by Dr. Lovick Dickey, *JMAG*, August, 1988, volume 7, page 619. His thesis is that the health care system in this country is on a collision course with the American economy. It is commendable that Dr. Dickey was concerned enough to take the time and trouble in his retirement to pinpoint this issue. This attestation to the purity of his motives adds to the poignancy of his plea. He states: "Approximately 50% of corporate pre-tax profits in this country went for health care costs last year." And further: "Some system of rationing, probably not decided by physicians, is a reality that looms dead ahead."

My reason for comment is that I have been a member of the Blue Cross/Blue Shield Board and the Atlanta Health Care Alliance for several years and have been eyeball to eyeball with health care costs. Often when I have spoken with physicians about this, the response is, "that's not my problem" or "that's not our problem." The nearly tearful frustration to which this reduces me has finally given away to some rationality, and I would like to suggest what I hope will be some clarification.

I think there are three separate aspects to this situation that we may blur in our minds as one. The first is the existence of the problem. The second is the cause of the problem, and the third is the solution to the problem.

To those who think there is no problem, they would do better to read no further.

To those who think that physicians are not the cause of the problem, I would say they are largely right, although I believe we do have a degree of responsibility.

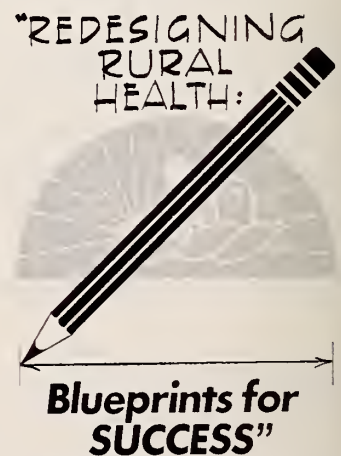
To those who say the solution to the problem is not our responsibility, I would beg inability to judge accurately but would suggest that there is little merit and almost no time to debate that question. Rather, I would suggest that the solution is critical to our country and to our profession and that not only are we in the most knowledgeable position to develop that solution, but that a solution by any other entity is much less likely to be as appropriate. The alternative to any solution at all (i.e., a do nothing attitude by everyone concerned) will preserve the status quo as long as Corporate America can "hang on." In the aggregate, this group is the key to a continuation of fee-for-service medicine and is the last major bastion of defense against nationalization of our health care system. That they are wavering in their opposition to national health insurance is exemplified by the recent, perhaps more than rumor, that General Motors is considering reversing its position.

Loud in its silence but intricately interwoven throughout any consideration for action is the fact that there is little if any room for a dogmatic, pedantic, or all inclusive generalizations. Virtually every allegation, assertion, and activity has some degree of validity. Almost every utilization of health care services can be defended with some degree of justification, miniscule though it may be. The "making sure" mentality is very real. To preserve a system of insurance-type reimbursement, therefore, we must develop a system of reasonable and affordable risks, different levels of co-payment for different procedures involving different people and different age groups, perhaps a further

variation in the co-pay formula based on the patient's income, and judicial protection for the physician complying with the developed standards. (Note the recent recommendations for the latter released by the AMA and its specialty societies in January of 1988). The medical profession has been moved, unwittingly, more and more into the position of a public utility in recent years and certainly it needs and deserves some protection pertaining thereto. It's disquieting that the legal profession, acutely cognizant of the liability issues involved in the practice of medicine, has advanced no innovative solution, though such would obviously benefit the entire nation and the world.

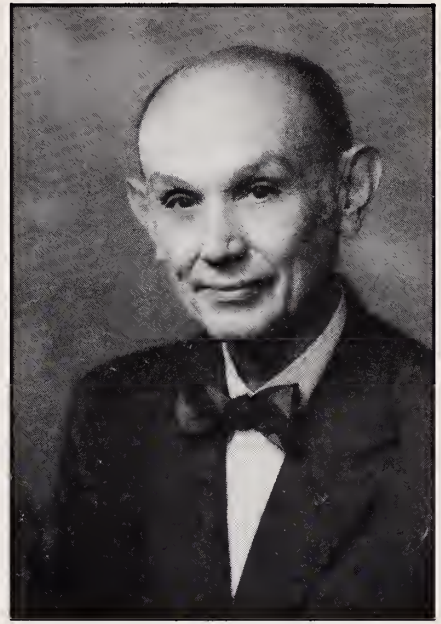
If we do not devise a program for affordable health care on a private basis, then the elements incorporated above will very likely accrue to us in a plan for national health service mandated by the federal government.

Sincerely yours,  
Louis H. Felder, M.D.  
Internist, Atlanta



National Rural Health Association  
12th Annual National Conference  
April 30-May 3, 1989  
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*Joseph P. Bailey, Jr., M.D.*

**C**ONSIDERATION for the medical care of the future is a seemingly distant event, elusive and poorly understood. And yet progress in medicine has been real and clearly defined in the current betterment of mankind and should be anticipated to continue at a somewhat predictable rate. If this is not the case, then why not?

Progress has occurred in a setting relatively unencumbered by governmental controls and one dedicated to stated altruistic principle. The current situation of improved health and longevity has in part emanated from this effort, but its development and application have been associated with monetary costs. This has been predictable and yet expressed with alarm by some when realizing medicine's relationship to the GNP.

Attempts at control of medical care appear directed at decreasing monetary outflow,

regardless of outcome. The dedicated effort of the physician and his or her preparation to provide this effort seem to be lost in the minds of those dealing with financial support. Presently, this is exemplified in severely limited payments for neonatal care of premature infants, even in the face of known enhanced survival rates with improved care.

We must all join to convey the true value of medicine to the public and those who are in government. Great pride in our profession and its accomplishments must be a part of our being, not to be lost in today's crass, and sometimes demeaning, world. The prediction of tomorrow's medicine is ours to control. It requires the continued unselfish and dedicated effort that has always characterized the physician.

May this season of the year bring joy and happiness to us all.

*Joseph P. Bailey, Jr.*

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Thurblly, Tara L., Family Practice — Muscogee — (Resident) 1515 Hogansville Rd., #55, LaGrange, 30240

Train, Jordan D., Internal Medicine — MAA — (Resident) 3036-F Clairmont Rd., Atlanta, 30329

Tucker, Debbie A., Pediatrics — Georgia Medical — (Active N2) 4 Medical Arts Center, Savannah, 31419

Turner, Dennis, Jr., General Surgery — MAA — (Active) 25 Prescott St., Ste. 6436, Atlanta, 30308

Twillie, Twyla M., Family Practice — Muscogee — (Resident) 2840 Warm Springs Rd., #M-7, Columbus, 31904

Tyrel, Robert T., Radiology — MAA — (Resident) 2870 Pharr Ct. S., #2110, Atlanta, 30305

Watson, Ben L., Internal Medicine — Georgia Medical — (Active N2) P.O. Box 14359, Savannah, 31406

Wiggins, Carol A., Allergy/Immunology/Internal Medicine — MAA — (Active N2)

William, Diana R., Emergency Medicine — MAA — (Resident) 617 Summit North Dr., Atlanta, 30324

## PERSONALS

### Decatur-Seminole CMS

**David Guttman, M.D.**, has recently opened a new pediatric practice in Bainbridge. Dr. Guttman had previously practiced in Greenville, AL, in a multi-specialty group of physicians.

### Dougherty CMS

**Jeffrey R. Hoopes, M.D., F.A.C.C.**, a cardiologist and Director of the cardiac catheterization laboratory at Phoebe Putney Hospital, has been elected president of the Dougherty County Division of the American Heart Association.

### Medical Association of Atlanta

**Oliver A. Sorsdahl, M.D.**, Director of Nuclear Medicine at Georgia Baptist Medical Center in Atlanta, has attained Fellowship in the American College of Nuclear Medicine. He was one of eight members so honored.

During the meeting Dr. Sorsdahl was also chosen vice president-elect, a member of the Board of Representatives of the college, and its alternate delegate to the AMA.

**Gwynne T. Brunt, Jr., M.D.**, of Atlanta, was named as a Fellow of the American College of Radiology. Dr. Brunt was among 136 new Fellows named by the College's Board of Chancellors.

## Hall CMS

**William C. Ferrell, M.D.**, of Gainesville, was one of 136 persons named as Fellows of the American College of Radiology.

## DEATHS

**Alexander G. Little, Jr., M.D.**, of Valdosta, a retired surgeon, died of Alzheimer's disease recently. He was 75.

Dr. Little practiced in Valdosta from 1945 until his retirement in 1974. For many years, he was on the surgical staff of Little-Griffin Hospital.

Dr. Little was a graduate of Davidson College and the Johns Hopkins University School of Medicine. He was a Fellow of the Mayo Clinic. During World War II, he was a surgeon in the Army Medical Corps in North Africa and Italy.

Dr. Little was the executor of the Kate Bentley Estate, which was dedicated to providing medical attention for underprivileged children in Valdosta. He was appointed to the State Board of Health during the administration of Georgia Gov. Carl Sanders.

## QUOTE

*A friend may be often found and lost, but an old friend never can be found, and nature has provided that he cannot easily be lost.*

SAMUEL JOHNSON

## DECEMBER

3 — *Atlanta: Dimensions of Attention in Children.* AMA Category 1 credit, PREP prescribed credit, and ACFP prescribed credit. Contact Education Department, Scottish Rite Children's Hospital, 1001 Johnson Ferry Rd., Atlanta 30363. PH: 404/275-2148.

3-4 — *Atlanta: Regional Anesthesia: Surgery, Obstetrics, and Pain.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

5-9 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

7-9 — *Atlanta: Nuclear Medicine Update: Infection, Renal and Cardiac Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

9 — *Atlanta: Current Topics in Rheumatology for the Non-Specialist.* Category 1 credit. Contact Frederic C. McDuffie, M.D., Piedmont Hospital Arthritis Center, 1968 Peachtree Rd., Atlanta 30309. PH: 404/350-1750.

10 — *Atlanta: Implementing Recent Cholesterol Findings in Your Practice.* Category 1 credit. Contact Jane Greene, Medical College of Georgia, Augusta 30912. PH: 404/721-4861.

12-16 — *Atlanta: Modern Methods of Diagnosing and Treating Diabetes Mellitus and Its Complications.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

## JANUARY 1989

9-13 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

23-27 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

23-27 — *Atlanta: Modern Methods of Diagnosing & Treating Diabetes Mellitus & Its Complications.* Category 1 credit. Contact office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

## FEBRUARY 1989

6-10 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

6-10 — *Atlanta: Modern Methods of Diagnosing & Treating Diabetes Mellitus & Its Complications.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

10-11 — *Augusta: Flexible Fiberoptic Sigmoidoscopy.* AMA Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

11-18 — *Copper Mountain, CO: New Horizons in Anesthesiology.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

18-22 — *St. Thomas, Virgin Islands: Clinical Problems in Gynecological Surgery.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

20-24 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

20-24 — *Atlanta: Modern Methods of Diagnosing & Treating Diabetes Mellitus & Its Complications.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

## MARCH 1989

2-9 — *Keystone, CO: Snow Job in Gynecology & Obstetrics.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

3-4 — *Atlanta: 26th Annual Emory/Grady Post-Graduate Ophthalmology Conference.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

3-4 — *Atlanta: Pediatric Orthopaedic Seminar.* Category 1 credit. Contact Darlene Baugus, CME Ed. Coor., Ed. Dept., Scottish Rite Children's Hosp., 1001 Johnson Ferry Rd., Atlanta 30363. PH: 404/257-2148.

6-10 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.





## ALLAN J. HAMILTON, M.D.

Neurosurgical Resident and Research Fellow,  
Massachusetts General Hospital, Boston, Massachusetts.  
Captain, U.S. Army Reserve.

**EDUCATION** Ithaca College, B.A. (Magna Cum Laude);  
Hamilton College (Pre-med); Harvard Medical School.

**RESIDENCY** General Surgical Internship. Neurosurgical  
Residency, Massachusetts General Hospital.

**CONTINUING EDUCATION** Neurology and Neuro-  
surgery Research Fellowship Training, National Institutes  
of Health.

**OUTSTANDING ACHIEVEMENTS** Olsen Memorial  
Fellowship, National Masonic Medical Research Foundation;  
Albert Schweitzer Fellowship, International Albert Schweitzer  
Foundation; Harvard Medical School Cabot Prize for Best  
Senior Thesis; recently published article, "Who Shall Live  
and Who Shall Die" in Newsweek Magazine.



“The work I’m doing in the Army Reserve fits perfectly with my academic research interests in civilian life. The Army is very concerned with the effects of high-altitude cerebral edema, which is a mirror model of cerebral hypoxia, something I deal with every day in our neurosurgical intensive care unit. I couldn’t ask for a smoother transition. And that’s true for a lot of Reserve physicians. All we really do is change our clothes, not our mindset.

“Some of the projects the Army is undertaking are on the cutting edge of research. For example, I’m currently involved in developing for the Army a prototype of a non-invasive intracranial pressure-monitoring device that we hope will allow us to measure pressure changes as the brain swells – without drilling holes in the skull. If we can get our design to work, such a device could revolutionize high-altitude medicine as well as civilian neurosurgical care.

“The quality of medicine and the caliber of people I’ve been associated with in the Army Reserve are, without question, equal to civilian hospitals. In fact, I’m giving serious consideration to applying for an active duty academic position in Army Medicine when my residency ends at Massachusetts General.”

Find out more about the medical opportunities in the Army Reserve. Call toll free 1-800-USA-ARMY.

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Soldier being examined for effects of high-altitude cerebral edema.



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**Contraindication:** Known allergy to cephalosporins.

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Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

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- Discontinue Cecilor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Cecilor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in

moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.

- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Cecilor penetrates mother's milk. Exercise caution in prescribing for these patients.

#### Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

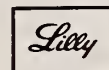
- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Cecilor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
  - As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
  - Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonía, dizziness, and somnolence have been reported.
  - Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%, and, rarely, thrombocytopenia.
- Abnormalities in laboratory results of uncertain etiology**
- Slight elevations in hepatic enzymes
  - Transient fluctuations in leukocyte count (especially in infants and children)
  - Abnormal urinalysis; elevations in BUN or serum creatinine
  - Positive direct Coombs' test
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About the Cover Artist

Dorothy Gillespie



THE FESTIVITY of the Holiday Season is suggested by the painted enamel strips of stainless steel by New York City artist, Dorothy Gillespie. A native of Roanoke, Virginia, Ms. Gillespie is a graduate of the Maryland Art Institute; she received her Doctor of Fine Arts (Honoria Causa) degree in 1976 from Caldwell College in New Jersey.

Dorothy Gillespie's work grows out of the object-orientation of Modernism while at the same time representing the "break that is a continuation of Modernism." She considers herself to be unique but, having "an awesome respect for the past," knows that being part of a *zeitgeist* does not obviate individuality, especially in a period of pluralism. "I don't know where I fit in," she says, but fifteen years ago she knew it was not as a painter: "I didn't want to paint myself into a corner by defining something to its essence." What had kept her out of sculpture was that "there was no color in it." She says now: "It was good I didn't get into sculpture earlier, because I would have been trapped with the way it was. I have been to Greece five times. Realizing Greek sculpture was painted freed me to work '3-D' in color." Over the years, she has turned more and more to metal, backing Mylar with galvanized steel. (Introduced at the DuPont Pavilion of the 1964 World's Fair in New York, Mylar is a reflective material lighter than cellophane and stronger than steel of its own thickness.)

Gillespie loves to experiment with movement, texture, and color in exploring the paths she has uncovered with her genre. She cherishes the struggle as well as the exhilaration implicit in her art; otherwise it would fall into decoration. Presence is her chief ambition. "That's the indescribable thing about art," she says. "It either has it or it doesn't. If not, it isn't art in my estimation. It's like the feeling you have when someone's in the room with you; it goes beyond the canvas, being, image — it commands!" "There must be some reason why we make art," she says, "why it becomes priceless; the question has almost nothing to do with analysis — why some art is bigger than life and lasts longer than individual life. The artists I know with this respect for art [she means in

the past and the present] had the feeling they wanted to do something terribly important and were willing to sacrifice everything for it."

Ms. Gillespie does not presume to achieve this, but the effort ("both a privilege and a punishment") upholds her resolve. Her attitude toward art and her own work is compounded of religious devotion and hedonistic delight, causing her to say, on the one hand, "I feel very humble about art," and on the other, "I am completely at ease with what I do." Considering her commitment and contribution, both personal and artistic, she can claim with perfect confidence: "I feel right with my time."

Ms. Gillespie's work is shown exclusively in Atlanta at EVE MANNES GALLERY at Tula, 75 Bennett St., Suite 2B, Atlanta 30309; 404/351-6651.

Collections

- The Solomon R. Guggenheim Museum, New York
- Grey Art Gallery, New York University, New York
- Birmingham Museum of Art, Birmingham, Alabama
- Fort Wayne Museum of Art, Fort Wayne, Indiana
- Fine Arts Museum, Roanoke, Virginia
- Johnson Museum, Cornell University, Ithaca, New York
- The Museum of Art, Fort Lauderdale, Florida
- Lowe Museum, University of Miami, Miami, Florida
- Helena Rubinstein Pavillion, Tel Aviv Museum, Israel
- Radford University, Radford, Virginia
- The State Collection, Kessel Museum, Kassel, Germany
- The State Collection, Darmstadt Museum, Darmstadt, Germany
- The State Collection, Frankfurt Museum, Frankfurt, Germany
- Institute of Contemporary Arts, Lima, Peru
- Caldwell College, Caldwell, New Jersey
- Virginia State Theatre, Abingdon, Virginia
- Ohio Dominican College, Columbus, Ohio
- Human Relations Center, New School for Social Research, New York
- North Carolina Museum of Art, Raleigh, North Carolina
- Hollywood Federal Bank, Coral Gables, Florida
- Corroon & Black, Inc., Washington, D.C.
- Sigma Development, Richmond, Virginia



# Physician's Recognition Award Recipients

**L**ISTED BELOW are those physicians in Georgia who have earned the AMA's Physician's Recognition Award (PRA) from April through June, 1988.

*The Award was established by the AMA House of Delegates in 1968 "To recognize, encourage, and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a 3-year period to qualify for the Award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or cosponsored for Category I credit by organizations accredited for these activities.*

*We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:*

Abel, Warren Russell, Atlanta  
 Alexander, William Scott, Atlanta  
 Allen, Warren Russell, Atlanta  
 Alvarez, Hortensia W.,  
     Milledgeville  
 Anders, Patrick L., Riverdale  
 Anglyn, Derrell W., McDonough  
 Arias, Manuel, Roswell  
 Bawtinheimer, Gary George,  
     Roswell  
 Berman, Irwin Ralph, Brunswick  
 Bertram, Bradley Alan, Atlanta  
 Bhoomkar, Ashok, Atlanta  
 Bock, William Clifford, Decatur  
 Bongiorno, Frank Paul, Peachtree  
     City  
 Carr, Robert Joseph, Augusta

Chandlee, Robert Evan, Marietta  
 Chung, Soong Pyo, Dublin  
 Cook, John Robert, Fort Gordon  
 Cornwell, William Oscar, Fort  
     Oglethorpe  
 Cox, Daniel Baker, Waycross  
 Crimmisn, Laurence Tarver,  
     Albany  
 Crosby, Kay Rowland, Decatur  
 Davis, Billy Joe, Hartwell  
 Derrick, Howard C., Lafayette  
 Don Diego, Frank Richard,  
     Palmetto  
 Elrod, Dan Berlin, Dublin  
 Evans, John Sanford, Atlanta  
 Felder, Richard Emerson, Atlanta  
 Fink, Stacey Marc, Augusta  
 Fitzgerald, Edmund M., Dublin  
 Flatow, Jeffrey H., Lawrenceville  
 Fountain, Joel Robert, Forsyth  
 Geeslin, James Menard, Canton  
 Glass, Fredric Charles, Atlanta  
 Greenwell, Kevin Ray, Newnan  
 Grimes, George W., Milledgeville  
 Grooms, James Duane, Brunswick  
 Hancock, Charles Irwin, Atlanta  
 Harbin, William Pickens, Rome  
 Harper, William Nichols, Atlanta  
 Hartney, Thomas James, Martinez  
 Hawk, Ernest Terry, Duluth  
 Helton, Timothy David, Marietta  
 Herbst, Mark David, Decatur  
 Hersch, Steven Mel, Decatur  
 Hester, Thomas William, Martinez  
 Hostetler, Russell M., Macon  
 Hotz, James Allen, Albany  
 Inman, William Oliver, Brunswick  
 Jarrard, William Howell, Augusta  
 Kadis, Gerald Neil, Thomasville  
 Kehl, Douglas Keith, Atlanta  
 Kell, Michael Jon, Stone Mountain  
 Kellett, Barto Paul, Atlanta  
 Kushner, Robert Lee, Atlanta  
 Kwok, Ken Kunse, Marietta  
 Majors, Roy Allen, Augusta  
 Manning, Donald E., Atlanta  
 Marmolejo, Alfonso, Atlanta  
 Mayher, William Edgar, Albany  
 McCamy, John Coston, Marietta  
 Meacham, Jack Reeves,  
     Summerville  
 Meguiar, Ramon Vernon, Jesup  
 Melcher, Richard Earl, Augusta

Michels, Mark, Atlanta  
 Miller, Cecil Le Royce, Buford  
 Neal, Ruth E. R., Augusta  
 Ng, Chun-Ho Patrick, Savannah  
 Nichols, Joseph Jacobs, Atlanta  
 Oliver, Robert Walter, Dublin  
 Orr, William Wood, Athens  
 Park, Ui Ho, Dublin  
 Parsons, Richard C., Decatur  
 Patterson, Anthony Curtis, Evans  
 Pelaz, Felix, Riverdale  
 Petry, L. Jeannine, Augusta  
 Piedrahita, Pablo, Conyers  
 Pressley, Kevin Ray, Columbus  
 Pressley, Rhonda D., Columbus  
 Price, Billy Ray, Moultrie  
 Rankin, Michael D., Atlanta  
 Reitt, J. Peter, Atlanta  
 Rey, Charles Joseph, Austell  
 Reyes, German M., Riverdale  
 Roberts, Ralph Donald, Fitzgerald  
 Rogers, Laura B. Quillian, Augusta  
 Schneider, Robert Kirwin, Roswell  
 Shannon, George William,  
     Columbus  
 Shapiro, Michael Ira, Tucker  
 Shoffner, John McKinley, Decatur  
 Silverman, Stuart Harold, Decatur  
 Sommerville, Margaret J. L.,  
     Atlanta  
 Spurlock, John W., Evans  
 St. Clair, Jane Turley, Atlanta  
 Stebler, Michael E., Waycross  
 Stubbs, David Manning, Albany  
 Stewart, Larry Daniel, Perry  
 Sullivan, Robert F., Carnesville  
 Theriot, Georgia Marie, Newnan  
 Tran, Chuong Dinh, Augusta  
 Wadhwani, Rita Gidwani, Atlanta  
 Wakefield, Marsha Louise,  
     Augusta  
 Warren, Howell R., Atlanta  
 Washington, James Edward,  
     Atlanta  
 Widell, Jeffrey L., Decatur  
 Wilhelmi, Louis James, Augusta  
 Williams, Charles Dirk, Acworth  
 Williamson, Jackie Larae, Acworth  
 Witt, Michael Anthony,  
     Chatsworth  
 Wood, Richard Elgin, Columbus  
 Wright, Stephen Cole, Atlanta  
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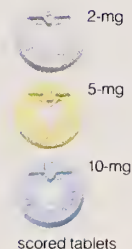
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## *History of the Medical Profession — The Perfect Holiday Gift*

*"What experience and history teach is this — that people and government never have learned anything from history or acted on principles deduced from it..."*

**N**OTWITHSTANDING the pessimistic words of Georg Wilhelm Friedrich Hegel, 19th Century philosopher, a better knowledge of Georgia's fascinating medical history could serve as an important guide to understanding some of the current problems being faced by physicians and their families.

The MAG Auxiliary's book, *The Medical Profession in Georgia, 1733-1983*, was published in late 1983 with three purposes in mind: 1) to bring an accurate history to those unaware of their past; 2) to raise funds for the Auxiliary-sponsored William R. Dancy, M.D. Medical Student Loan Fund for deserving Georgia medical students; and 3) as medicine's contribution to our state's 250th birthday celebration.

These objectives have been successful and ongoing parts of the Auxiliary's annual programs since publication of the book, and to date their influence has reached far beyond the borders of Georgia. In addition to the copies of book sold to be placed in Georgia doctors' offices, hospital libraries, public libraries, college collections, and private homes, the Auxiliary can boast that today many college and medical libraries over the country have on their shelves at least one copy of *The Medical Profession in Georgia, 1733-1983*.

These include such well-known institutions as The University of California at San Francisco, The University of Alabama and the public library of Birmingham, Yale University, Princeton University, The St. Louis Society for Medical and Scientific Education, the Library of the College of Physicians of Philadel-

phia, The Osler Library of McGill University, Montreal, Canada, The Medical Center Library, Duke University, The American College of Obstetrics and Gynecology, Washington, D.C., The University of Wisconsin Center for Health Sciences Library, Madison, Wisconsin, and Howard University, Washington, D.C.

**S**everal publications in various sections have periodically published reviews of the book which stimulated sales from outside Georgia, among them *The Journal of the American Dental Association* and the *Bulletin of the History of Medicine*, published by The American Association for the History of Medicine and The Johns Hopkins Institute of the History of Medicine.

Newspapers and magazines over Georgia also have reviewed the book with favorable comments. Letters have come from physicians and other readers in many areas of the country, congratulating the Auxiliary for making known the story of Georgia's medical history. These will fill a large scrapbook to be placed later in the archives of the Auxiliary.

Perhaps more important have been the messages from recipients

of aid given through the William R. Dancy, M.D. Medical Student Loan Fund.

"I could never have completed my final year in medical school had it not been for help given me by the Dancy Fund," declared one of Georgia's present-day female physicians.

A male physician revealed: "When a third-year medical student with a wife and three children reaches the end of a month and finds there is no money left and no food on the table, he and he alone knows the value of a small loan from the Dancy Fund."

**F**or those physicians and their wives who have not yet bought the Auxiliary's book for themselves, to give as a gift to a friend, or to present to a library or school, the book is still available by sending a check to Evelyn Ward Gay (the author who is the wife of an Atlanta physician), at 911 Vistavia Circle, Decatur, GA, 30033. The price for the 400-page hardback, illustrated volume is \$25 per copy, postage paid. All proceeds go to the Dancy Fund. Even if you already have bought a copy of the book, why not buy another one now as a special gift for someone else this holiday season?

*During a recent medical meeting at the Hyatt Regency Hotel in Cincinnati, Ohio, Evelyn Ward Gay (center), author of The Medical Profession in Georgia, 1733-1983, discussed the book with Dr. and Mrs. Ronald E. Overfield, of Nashville, active members of the Tennessee medical association and its auxiliary.*



## Christmas Time

*"Christmas time. The only time I know of, in the long calendar of the year, when men and women seem by one consent to open their shut up hearts freely and to think of the people below them as if they really were fellow passengers . . . and not another race of creatures bound on other journeys."*

CHARLES DICKENS *A Christmas Carol*

**W**E WERE WINTERING in St. Louis when it happened. Bleak, dreary, cold St. Louis, with Midwestern snow all about. Charles Dickens could have been describing the weather in St. Louis when, in a novelette called *The Chimes*, he wrote about London weather: "and a breezy, goose-skinned, blue-nosed, red-eyed, stony-toed, tooth-chattering place it was to wait in in the winter-time, as Toby Veck well knew. The wind came tearing around the corner, especially the east wind, as if it had sallied forth, express, from the confines of the Earth, to have a blow at Toby."

But it was Christmas, and all about us was the feel of The Season — the smells, the sounds, and the magic anticipation of things about to change. The daily grind of early up and late to bed would be interrupted, at least for a time, by the need to close the operating rooms and gear down the admissions. The entire pace

of life would be rearranged. Christmas in the South surely brought much of the same, and that familiarity we would miss, but here was real, sure enough, bone-chilling cold. And snow!

It seemed proper in this secure and comfortable world which we shared with the first two children, they were then 2 and 4 years of age, that close friends join us for the tree decorating. We were "ordinary" surgeons and they neurosurgeons. Betty and Herb Lourie were that comfortable mixture of confident and open happiness that, among our several friends, brought their names to us first. They came then, and with them their 3-year-old daughter. The little apartment but barely confined the evening's activities as spirits lifted spirits. Modest but healthy food assauged appetites. A few songs were sung and then the tree was trimmed. The evening drew to a close in a comfortable and happy way. As Good Presbyterians, we had that secure feeling that this particular evening had been spent as a Christmas should be spent.

The dishes were being put away in the kitchen when Betty Lourie said to the good Presbyterian wife that the invitation to share the evening was generous and understanding. It had been particularly appreciated. The words fell with lack of understanding upon the good Christian who, with easily

perceived confusion, expressed her lack of comprehension.

"You do know we are Jewish?," questioned Betty. She went on to say that the daughter, while being brought up in a Jewish family, had been observing all of the activity as Christmas day drew near and was to some degree perplexed by it all. They had, of course, enjoyed the evening themselves, but they appreciated particularly, she said, the opportunity for their daughter to see and understand more directly what it was all about.

And so the evening came to a happy and joyous ending. No, we knew not that they were Jewish. We had known them, and closely, those years past, but had known them as friends with no need of ecclesiastical identification. Knew them as people who because of sincerity and truthfulness and trustworthiness and a hundred other virtues we liked to be around. And now we knew them as good company. As good Christmas tree trimmers and carol singers. We now knew them as Jewish, astonishing us all, they as well, that this bit of information made no difference at all.

**T**he close ties, because of distance, faded, but the memories and the friendship went on as the training days came to an end — went on until Herb Lourie was shot to death in his front doorway by a crazed patient some years later. He died as he



## *On Billy Mitchell*

had lived much as we had found him and his family that Christmas night, for the obituary talked of the endless activities to which he devoted so much of his time and his life. Not Jewish activities, nor Christian either. Secular perhaps one might call them, for they cut across the lines dividing humankind. He seemed not to know that boundaries existed — or else failed to recognize them.

And so we come again to another Christmas and afterwards a New Year. They say it is a Christian holiday. As for me, I know not. It seems to have grown, to have become, not only that but something more. A time of relaxing the constraints of time itself. A place for taking stock and rearranging priorities. Surely for this family at least, it reminds us that we are all in this place, on this earthly spaceship, whether we be Jew, Christian, Moslem, or "other" in our theologic belief. For we can still hear the happy and incredulous voice of Betty Lourie asking, "You do know that we are Jewish?"

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**B**ILLY MITCHELL, M.D., died the other day. On September 10, 1988, to be exact. His wife, Millie, called him Claude. The shingle out front at the office in Smyrna said W. C. Mitchell, M.D., but most of us who knew him simply called him Billy.

I feel better now that he is gone. Those last few years were tough ones, what with the strokes and the aphasia and finally the total confinement to bed. One had to feel some sense of comfort and satisfaction that his struggle was over.

He was a general practitioner in the real sense of the word. He had come to Smyrna 47 years earlier following a schooling at Emory and a training at "the Grady's." He did a little bit of everything during those 47 years as far as medicine is concerned. He even found time to be elected President of the Medical Association of Georgia in 1971. To the best of my knowledge, he is the only one from the Cobb County Medical Society we have ever had in that position. He went farther than that, however. He recognized that the physician, blessed with a good education and granted the privilege to care for the health of others, needed to return some of that prestige to his community. And so it was that he helped to establish the Smyrna Chamber of Commerce and occupied the position of Chairman of the Cobb County

Board of Education for 10 years. He saw the practice of medicine as something more than a way to make a living.

**Y**ou can't think about Billy Mitchell without remembering the smile. The quixotic smile, the humorous stories of which he was full, and then the laughter that shook the short, statured, overweight body until everyone within ear shot was laughing with him. If he had ever recognized adversity, he would simply have told it a joke and begun to laugh back at it. He laughed with his friends, he laughed at himself, but beyond this he took his responsibilities seriously. He was the epitome of the person Henry Van Dyke was talking about, "It is required of a man that he do more than stand tall in this world. He must stoop down and lift mankind a little higher."

And so it was that I felt better, and smiled a bit, when I looked in the casket. He seemed to smile back. "Keep laughing at the odds. Keep looking out for somebody other than yourself," he seemed to say.

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# MRI UPDATE

## MRI Advances the Detection of Avascular Necrosis

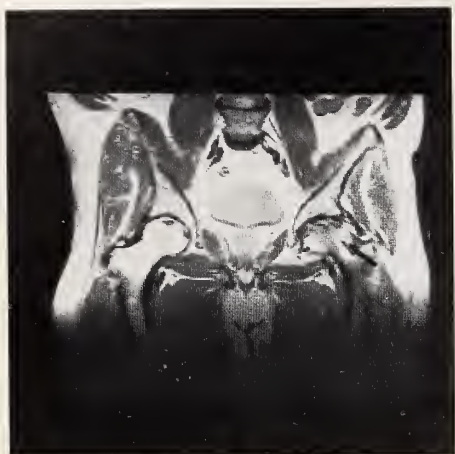


Figure A



Figure B

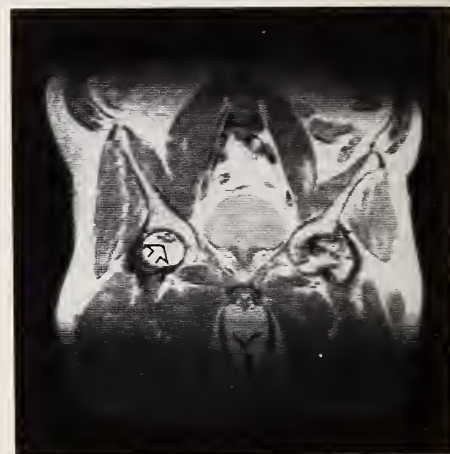


Figure C

**HISTORY:** This patient is a 50 year old male presenting with left hip and leg pain. There was no history of trauma. The radiographs of the left hip suggest advanced avascular necrosis (AVN). Radionuclide bone scan revealed non-specific generalized increased radioactivity involving the entire left hip, and the right hip was normal.

**SCAN:** Both hips were imaged in axial and coronal projections. The left hip has multiple findings consistent with advanced AVN, such as: (a) irregular low signal areas mixed with high signal areas involving the superoanterior left femoral head [Fig. A], (b) irregularity and flattening of the articular surface of the femoral head indicating fracture and collapse of the articular surface, (c) large effusion in the joint capsule [Fig. B]. The right hip reveals early changes of AVN, characterized by a low signal intensity margin around a central area of increased signal intensity involving the superoanterior femoral head [Fig. C]. No associated fracture, collapse, or evidence of joint effusion is demonstrated in the right hip.

**MRI HIGHLIGHTS:** The advantage of MRI in this study is twofold: (1) MRI corroborated radiographic findings of advanced AVN in the left hip, and, (2) MRI disclosed the incidental finding of early AVN in the right hip which was not clinically or radiographically evident. MRI is the most sensitive imaging technique for early detection of AVN, increasing the success of surgical treatment (core decompression). Although the clinical symptoms may be unilateral, the process may be bilateral; occult lesions are most likely to be missed by bone scintigraphy and CT scan. Radiographic changes are not evident until marked bone destruction has occurred.



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# Quiet Thoughts

From BYNUM's scrapbook . . .

## THE BRIDGE BUILDER

An old man going a lone highway,  
Came at the evening cold and gray,  
To a chasm vast and deep and wide.  
The old man crossed in the twilight dim;  
The sullen stream held no fear for him,  
But he turned when safe on the other side,  
And built a bridge to span the tide!

"Old man," said a fellow pilgrim near,  
"You are wasting your strength with building here.  
Your journey will end with the ending day.  
You will never again pass this way.  
You've crossed the chasm deep and wide.  
Why build you this bridge at evening tide?"

The builder lifted his old gray head,  
"Good friend, in the path I have come," he said,  
"There followeth after me today,  
A youth whose feet must pass this way.  
This chasm, which has been naught to me;  
To that fair-haired youth, may a pitfall be;  
He too must cross in the twilight dim —  
Good friend, I am building this bridge for him!"

W. A. ORONGALE

## THE JOURNEY

When night has come,  
I know that trusted hands the throttle hold —  
I know that steady rails and miles unfold —  
I know that endless watchers guide my way —  
This is my right — all for the fare I pay.  
I fall asleep within a well-laid birth —  
And we speed on across the peaceful Earth —  
Till day has come.

When night has come,  
And come it must to all the sons of men,  
And that long journey starts at last, will then  
Steady hands be at the pilot wheel?  
Will angel watchers guard the bow and keel?  
Will all the fare be paid, That I by right  
May fall asleep in peace through the long night —  
Till day has come?

*Richard Bynum Weeks, M.D.  
Savannah*

*We invite contributions to this Department. Please send them c/o the Journal,  
938 Peachtree St., Atlanta 30309.*

## Hospitals Take Stands on Budget, Legislation

**T**HE Georgia Hospital Association is planning to present to Gov. Joe Frank Harris a list of proposals for consideration in the state's fiscal year 1990 budget. Most of the proposals focus on improving Medicaid coverage and reimbursement as recommended by the Department of Medical Assistance. Some of the budget proposals were developed by GHA's Council on Smaller Hospitals and designed to meet the financial problems of Georgia's rural hospitals. The proposals include the following:

- Medicaid funding for swing-bed services for rural hospitals that have fewer than 100 beds.
- Expanded Medicaid coverage that would include pregnant women whose family incomes are below 125% of the federal poverty level. GHA also proposes that coverage gradually be expanded even further to include women whose incomes fall below 185% of the federal poverty level. Currently, Medicaid provides maternity coverage only to women who have incomes below 100% of that level. The wider coverage, says GHA, would significantly reduce the amount of neonatal care now required in the state.
- Allowing AIDS patients to be served by the state community care program. That program provides home services to patients who are eligible for nursing home care.

- Higher reimbursement for nursing home patients who require more intense services.

In addition to its budget recommendations, the hospital association has developed the following positions that it will support during the 1989 General Assembly:

*Revisions to the Nonresident Indigent Care Act.* Most counties

in the state do not help pay for health care for the poor, and the cost of that care falls on the counties that do provide hospitals. GHA's position is that all counties should help finance the health care for their medically indigent citizens. It supports a revision of the law that would make each county responsible for the cost of care provided to its indigent citizens by a hospital in another county when the first county does not provide that treatment.

*Risk pool for uninsurable persons.* Many Georgians cannot purchase health insurance because of pre-existing illnesses, thus making it difficult for some small employers to provide group health plans. GHA supports the creation of a risk pool that would expand health insurance to uninsurable persons.

*Open meetings.* The 1988 revision to the open meetings law requires that hospital authority committee meetings comply with its provisions. Thus, hospital authorities cannot discuss the development of new services without giving their competitors an unfair advantage. The hospital association supports the exemption of hospital authority committees from the law as well as of hospital authority boards when discussing the acquisition of real property, the expansion of health services, the preparation of certificate of need applications, the investigation of potential claims, and medical staff recruitment.

*Office of Rural Health Care.* The State Health Planning Agency's Rural Hospital Task Force has recommended the creation of an Office of Rural Health Care. The office would be part of the Department of Community Affairs, and it would help rural communities with health care planning as well as with research of health care issues. GHA

supports the establishment of the office.

## Hospital Fight for an end to Medicare cuts

**H**OSPITALS throughout the country are in the middle of a campaign aimed at stemming further cuts in Medicare reimbursement.

The campaign, which is headed by the American Hospital Association, encourages voters to contact their Washington representatives and ask for an end to the continuing cutbacks in hospitals' Medicare payments. The goal of the campaign is to generate three contacts for every licensed hospital bed, or a total of 1.5 million contacts.

The AHA points out that when the Medicare prospective payment began 5 years ago, Congress promised to increase the reimbursement rates each year by an amount large enough to cover the increase in costs. Yet since that time, however, Congress has failed to produce those increases by \$32 billion. As a result, hospitals' profits fell to 0.1% in 1987, and nearly half of all hospitals in the country are expected to lose money caring for their Medicare patients next year.

One result so far that the campaign has brought about is a resolution introduced by Sen. Paul Simon (D-IL) to protect Medicare hospital payments from budget cuts in FY 1990. Although the resolution is non-binding, Simon has said it "sends a strong, clear signal that we have a problem." Joining in the support of the resolution were Sens. Nancy Kassebaum (R-KS) and Dave Durenberger (R-MN), and Reps. Barbara Boxer (D-CA), Nancy Johnson (D-CT), and James Oberstar (D-MN).

*(This department is sponsored by the Georgia Hospital Association.)*



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# The Future Effect Of AIDS On Your Insurance Plans

## Answer This Question:

If in the 1970's and early 1980's you had known what you know now about medical malpractice premiums, would you have been willing to purchase your coverage on a fixed, guaranteed cost basis?

Of course you would.

That type of opportunity exists today in an area that is likely to be as volatile as the malpractice area has been. I am referring to nonguaranteed life and disability plans.

The spectre of AIDS is casting a long shadow in the insurance community. Because of actual claims and expected claims, most nonguaranteed plans, and plans offered by companies that are not rock solid, will be severely affected. Unless you are positioned properly, you will see a doubling and tripling of your insurance rates,

and many plans will be cancelled altogether.

Professional Resource Group works only with physicians. We are committed to helping them keep their plan costs as low as possible without sacrificing quality.

Though costs can not be guaranteed on medical insurance, thousands of dollars can be saved each year; in fact, Professional Resource Group was able to offer an **annual savings in excess of \$19,000** for a medical practice in Atlanta.

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Typical Association Rate  
as of 10-01-87  
\$300 Deductible

AGE	EMPLOYEE	FAMILY
Under 35	\$ 50.00	\$157.00
35-39	\$ 63.00	\$189.00
40-49	\$ 93.00	\$260.00
50-59	\$148.00	\$370.00
60-64	\$211.00	\$498.00

\*A+ Rated" Carrier  
as of 05-01-88  
\$250 Deductible

AGE	EMPLOYEE	FAMILY
Under 29	\$ 34.00	\$ 91.00
30-39	\$ 38.00	\$113.00
40-44	\$ 49.00	\$127.00
45-49	\$ 59.00	\$142.00
50-54	\$ 70.00	\$155.00
55-59	\$ 84.00	\$169.00
60-64	\$101.00	\$186.00

\*The "A + Rated" carrier's premiums would be slightly higher in the Atlanta area. Rates and contracts are subject to change. A number of options are available including Maternity, Prescription, Dental, etc. at additional premiums. All premiums are subject to underwriting acceptance.

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# Diagnosing and Treating Chronic Pain

## *A Challenge for Both Practitioner and Patient*

James E. Anthony, Jr., M.D.

**T**HIS PAPER IS PROMPTED by the large numbers of complaints the Composite State Board of Medical Examiners (CSBME) has received about physicians who use scheduled drugs in the management of chronic pain states. Many physicians have been disciplined by the CSBME of Georgia for inappropriate use of narcotics in the treatment of benign chronic conditions. Guidelines for the practicing physician who is confronted with the common, serious, vexing problem of the treatment of chronic pain are presented.

Pain is one of the common symptoms that causes a patient to visit the physician's office or hospital. Acute pain, for the most part, lasting less than several weeks is generally well treated by usual measures. Pain lasting longer than 6 to 8 weeks may present a problem more difficult than the original cause of the pain. Since pain follows a stimulus, it would seem logical that removing the stimulus would result in pain relief. Unfortunately, this is frequently not true. Pain eventually may be triggered by factors not relating to the original stimulus. Consequently, the patient develops a learned stimulus.

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**Physicians must consider not only the pain mechanisms but also the psychologic factors and coping skills in the patient's problem, since there is a high incidence of iatrogenic complications in such patients, mostly from ill advised drug prescriptions and drug misuse.**

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Pain is a complex behavior pattern, and because of this the diagnosis of chronic pain is a very difficult task. It has been difficult to measure pain and difficult to classify its origin and type. Much of the investigation of pain is of a subjective nature.

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At the time this article was written, Dr. Anthony was Medical Coordinator of the Composite State Board of Medical Examiners.

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It is essential to understand the nature of pain and, if possible, provide a diagnosis and to develop a management plan. It is worth emphasizing, again, that the treatment of acute pain differs substantially from the treatment of chronic pain. It is also important at the beginning to make a distinction between tolerance and addiction.

### **Basic Pain Mechanisms**

The experience of pain begins with stimulation of specialized nerve endings, which are known as nociceptors. Such stimulation can be triggered by a large variety of stimuli of such magnitude to affect tissue damage. The activation of nociceptors is encoded into a set of signals — the so-called nociceptive stimulation — which are transmitted to the central nervous system. The encoding process, however, is still poorly understood in its biochemical complexity. Certain spinal cord neurons (the so-called wide dynamic range (WDR) neurons) have been identified which seem to have a long memory. Once they have been activated by a nociceptive stimulation, they are known to continue firing even after the offending stimulation has been

eliminated. The wide range of their firing fields may refer a painful perception far away from the original source of nociceptive stimulation. The presence and the characteristic of the WDR neurons offer an acceptable neuro-physiologic model for a chronic pain syndrome in the absence or long after an injury or a disease has occurred. Damage to a peripheral sensory nerve causes various abnormalities in the functioning of the central neurons leading to a condition which has been labeled "sensory deafferentation" or "sensory epilepsy." Sensory deafferentation offers another acceptable model to explain many painful syndromes associated with the damage of peripheral nerves, such as post-herpetic neuralgia and pain associated with multiple surgeries and extensive scarring. When nociceptive signals reach the brain, they are interpreted as a pain message and trigger a cascade of physical, emotional, and cognitive responses.

#### **Physical Responses to the Perception of Pain**

(1) Sympathetic arousal. This is quite common following a perception of pain. It may lead to multiple peripheral malfunctions, mostly consisting in altered blood flows to affected bodily parts.

(2) Inactivity. While inactivity is proper and necessary to provide rest and healing to an injured part of the body, too much inactivity past the healing time, resulting in poor physical fitness, may lead to serious malfunctioning affecting almost every system of the body.

#### **Emotional Responses**

The perception of pain, both in its acute and chronic forms, causes several emotional responses of which anxiety and depression are the best documented. In turn, both of these emotional disturbances lead to sympathetic arousal and to profound changes in lifestyles and activities of daily living.

#### **Cognitive Responses**

Individual values, attitudes, thought processes may be deeply altered by a painful perception, mostly in its chronic form, leading

to a possible loss of self-esteem, with a resultant state of "learned helplessness."

#### **Acute Versus Chronic Pain**

Acute pain is a relatively short, unpleasant experience which clearly relates to an identifiable pathologic condition. In acute pain, anti-nociceptive phenomena have been demonstrated to be at work, with outpouring of endorphin, serotonin, and other neuro-transmitters. On the contrary, chronic pain is a prolonged experience of continuous discomfort, which usually relates poorly to any documentable, pathologic condition, and/or in the absence of a pathologic condition. At the present, there is little evidence in the literature that any anti-nociceptive mechanism is significantly present in a chronic pain state.

#### **Practical Diagnostic Suggestions for the General Practitioner to Distinguish Between Acute and Chronic Pain**

A physician should be alerted about the possibility of a non-diagnosed chronic pain syndrome anytime he or she is confronted with a patient who complains of pain out of proportion anatomically, physiologically, and emotionally to any documented pathologic disorder. As far as personality type is concerned, most physicians seem to agree that the alcoholic with a history of substance abuse presents real problems with regard to prescribing addictive medication. The passive dependent person also gets hooked on drugs very quickly, so it is extremely important to be cautious in the use of controlled substances with them. The chronic complainer may also become addicted easily, and for this reason it is important for the physician to know the patient well before prescribing narcotics. Although there are those who believe that chronic pain can be treated with narcotics, such drugs have generally resulted in major problems. This type of treatment may interfere with proper treatment for pain.

Several attempts have been presented in the literature over the last decade proposing various classifications of pain based on multidimensional assessment models.

One of these models was proposed by Dr. Brena and his colleagues and is known as the Emory Pain Estimate Model (EPEM).<sup>1</sup> The EPEM is basically an operational definition of chronic pain patients obtained through the quantification of medical and psycho-functional data. It leads to a classification of pain, describing four classes of chronic pain states, for easy diagnosis by any physician who is familiar with the EPEM. The Commission on Pain and Disability of the Social Security Administration has clearly recognized the existence of a "chronic pain syndrome," which is peculiar for patients belonging to Groups A and B, but can also be present in patients of Groups C and D (Table 1). Both the EPEM and the Social Security taxonomies of pain may have significant clinical value to the medical practitioner, because they describe operationally every possible patient who presents himself to the physician with chronic pain complaints.

The chronic pain syndrome has been described by the Social Security Commission on Pain and Disability as follows: 1) pain complaints out of proportion to medical findings; 2) evidence of significant psychologic malfunctioning; 3) inactivity; 4) history of drug misuse; 5) history of abuse of the health care system; 6) history of social malfunctioning, which may precede onset of the chronic pain syndrome. The Social Security Commission has clearly stated that the *chronic pain syndrome should not be confused with a psychiatric disorder or with patient's malingering*. The Social Security Commission believes that the physiologic and psychosocial behavioral patterns inherent in the chronic pain syndrome can provide a basis for trained clinicians to distinguish between chronic pain and a pathologic pain from an identified tissue abnormality. Furthermore, the Commission recognized that the chronic pain syndrome is treatable and need not be a permanent condition. While a few individuals may improve spontaneously, others need the assistance of a concerted rehabilitation effort of trained professionals.



Clinical Features of Chronic Pain

(1) *Depression.* Because of the frustrating and unrelenting nature of chronic pain, the patient usually becomes depressed. This may be increased by an underlying endogenous depression which the patient had before the pain developed and makes the patient prone to developing a chronic pain syndrome.

(2) *Disability.* Chronic pain disables the patients mentally, physically, and spiritually, which may affect the function and eventual outcome of treatment.

(3) *Dependency.* Because pain is associated with a symptom of a disease process, pain is usually considered as meaning disease. The more serious the pain, the more serious the disease process is perceived to be. Consequently, when the pain is severe, the patient assumes that the disease is more serious and becomes dependent upon physicians for medication or surgery and support.

(4) *Disuse.* This has a tendency to put the disease process to rest, and although in general this is effective for acute disease processes, it is counterproductive in chronic pain states. Long rest periods result in decalcification of bones, softening of tendons and ligaments, and dysfunction of the musculoskeletal system, thus increasing the chronic pain.

(5) *Doctor shopping.* Patients try to find a quick fix and visit doctor after doctor without giving any one doctor the benefit of the in-depth circumstances which influence the pain. Each physician, because of his or her brief contact, provides some medication to relieve the pain. As these different medications accumulate, the patient can become dependent on them.

(6) *Drug abuse or misuse.* Patients are given the impression through our culture that there is a drug solution to most problems. Drugs are used in multiple prescriptions to relieve chronic pain, but this attempted solution becomes a part of the problem.

Management of Chronic Pain Patients

The Social Security Commission on Evaluation of Pain and Disability

has recognized that it is possible to establish protocols of evaluation of individuals complaining of chronic pain to establish an acceptable plan of management. Treatment and rehabilitation programs must be multimodal and time-restricted to be cost effective. Minimum standards for pain centers should include: 1) interdisciplinary (team) evaluation to include medical, psychologic, functional, sociologic, and vocational assessments; 2) quantitative measurements of dysfunction and therapy-related improvement; 3) rehabilitation goals, including detoxification from addictive medication, improvement of function, endurance, range of motion, lifting capacity and tolerance, patient training in self-control of automatic functions, muscle tension, self-care, stress management, and psychologic functioning; 4) specification of treatment objectives in a format ensuring informed consent; 5) measures of compliance with the rehabilitation goals by periodic reevaluation of medical, psychologic, and functional progress; 6) vocational and avocational counseling for patients with a pending disability claim, in order to facilitate patient return-to-work functioning.

At the present, there is no board certification to monitor the performance of physicians practicing pain medicine. There is an American Academy of Pain Medicine (Allogology) which is trying to obtain recognition by the AMA. Competent pain control facilities are certified by the Commission on Accreditation of Rehabilitation Facilities (CARF), which has established criteria of excellence for pain clinics, many of them quite similar to the criteria recommended by the Social Security Commission.

It is extremely important for physicians to realize that they cannot cure all patients and cannot relieve all pain. It is important to teach patients to cope with pain and get them off drugs, since dependence on drugs increases the pain. The body itself will manufacture endorphins which are suppressed when given pain drugs.

Sympathetic Nerve Blocks

Historically, sympathetic nerve blocks have enjoyed a peculiar role of usefulness in managing patients with chronic pain. The recent advent of electronic thermography has provided a clinical explanation for such usefulness. In an overwhelming majority of chronic pain patients, thermographic studies have shown evidence of "cold" patterns in the painful bodily area, which demonstrate a sympathetic malfunction, leading to a diagnosis of "sympathetically mediated pain." Such "cold" thermographic patterns usually are corrected following proper asympathetic block therapy within a structured pain rehabilitation program.

Psycho-Physiologic Reactivation

Because psycho-physiologic malfunctioning is a typical feature of a chronic pain patient, particularly in patients of Groups A and B (Table 1), a program of psycho-physiologic rehabilitation is mandatory. Key points in psycho-physiologic rehabilitation may include the following: biofeedback and relaxation training, psycho-physiologic counseling, physical and occupational therapy, and work programs for those with a documented vocational potential to return to the job market.

TABLE 1 — Classification of Chronic Pain States According to the Social Security Commission on Pain and Disability

Group A — Chronic pain, inability to cope, insufficient documented impairment for lack of pertinent medical findings.
Group B — Chronic pain, competent coping, insufficient documented impairment for lack of pertinent medical findings.
Group C — Chronic pain, inability to cope, documented impairment from pertinent medical findings.
Group D — Chronic pain, competent coping, documented impairment from pertinent medical findings.



## Drug Therapy

Drug therapy of pain is quite useful in acute and recurrently acute pain states. In chronic pain states, its value is questionable and often leads to iatrogenic complications and physical dependence on drugs — which are the common features of the chronic pain syndrome. The physician should be alert to the possibility of a chronic pain patient displaying the symptoms of a chronic pain syndrome and avoid prescription of habit-forming medication (opiates, tranquilizers, sedatives, etc.) in a patient with the operational characteristics of Groups A and B of the Social Security taxonomy.

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## Drug management of chronic pain patients requires a higher degree of sophistication than patients with acute pain.

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A number of physicians feel the source of pain is not significant, as patients with chronic headaches or extremity pain undergo nearly the same emotional changes as patients with low back pain. Consequently, the persistent pain, regardless of source, becomes a chronic pain syndrome. A recent report in the medical literature suggests that patients with chronic pain that are referred to pain clinics have more emotional pathology than those with persistent pain who are treated by their private physician. This would suggest that not everyone with pain of 6 months' duration develops chronic pain syndrome. Proper treatment of the chronic pain syndrome requires a comprehensive approach with an algologist, psychologist, physical therapist, and social worker/rehabilitation specialist.

One physician's experience with the proper treatment of patients with chronic pain requires the use of an-

algesics, anti-inflammatory medications, anti-depressant medications, and anti-anxiety medications. The use of narcotic analgesics in treating patients with chronic pain remains controversial. There are many medical records supporting the use of narcotics, for years if necessary, as a proper treatment and other reports that say narcotics should never be used in the chronic pain patient. An article by Purtenoy and Foley<sup>2</sup> suggests that chronic use of opioid analgesics in non-malignant pain can be done carefully. It requires fully informed consent from the patient, and it should be noted that the patients had failed non-narcotic therapy and knowingly entered into a trial of opioid maintenance. The risk of using alcohol or other drugs while taking the opioid is that psychologic dependence can occur and may last a lifetime. Evidence of inappropriate use, drug diversion, or hoarding should be pursued and managed firmly. If control cannot be maintained, opioid therapy should be discontinued.

The chronic use of major and minor tranquilizers can produce many of the same problems that are found with narcotic use. Some physicians have found that the prolonged use of Valium leads to drug habituation and increases emotional depression, complicating a problem with chronic pain. Chronic anxiety probably should not be treated with medication alone.

Interviews with physicians in pain clinics generally agree in failed pain syndromes. The proper treatment is to get the patient off everything. There are some pain states that cannot be controlled by any method. Non-steroidal drugs are far better than steroid drugs. It is extremely important to give emotional support. Usually it is not necessary to give addictive drugs. Drugs such as Darvocet or Tylenol #3 can occasionally be quite helpful. Patients on physically addicting drugs sometimes are suicidal, and they pose a real danger to themselves. If the practitioner can handle chronic pain with low doses of Codeine and Darvon and discuss the addictive nature of the problem, document what he/she has done, and never give an increase in the

drugs, it is possible to maintain these patients. Many physicians have told me that psychiatry is of little value in chronic pain states.

## Specific Pain States

In back pain, the patient needs rehabilitation exercises and increased activities. Stress management is important through group therapy. If the patient has had chronic pain, there will be depression, so psychologic counseling should be provided. Occasionally, anti-depressants may be used. Headaches should not be treated with physically addicting drugs. These patients need non-steroidal drugs and stress relaxation. Rarely, they can be given very small doses of physically addicting drugs, below an addicting dose. Several doctors have told me that phenobarbital is a good detox drug because it is "quick in and quick out." Valium poses a problem because it has a long half life and may stay in the tissues 28 to 32 days. If the patient is being detoxed and the doctor does not know he or she has been taking Valium, the patient may have seizures.

Treatment of chronic pain syndromes in which low back pain predominates comprises 90% of patients with pain. A gradual approach starting with non-steroidal drugs should be done after stopping all other drugs. If there is going to be any secondary gain, such as financial gain from the pain, then it is important to know this in the beginning. Some patients don't want to get well.

Some physicians have great confidence in TENS. Patients that have low back pain and who are working and undergo surgery with continued post-operative pain usually show some improvement after conservative treatment. Epidural steroid injections are very helpful here.

In general, arthritic patients do not present much of a problem. These patients have learned to live with pain and don't have unreasonable expectations.

## Treatment Modalities

**Blocks:** Sympathetic blocks, epidural steroid injections, trigger point injections, and other blocks



using high potency and long-duration anesthetic agents may be of value.

**Psychologic Intervention:** Psychologic testing is extremely important and helps to determine how the pain interferes with the patient's activities. This may bring out significant emotional features relating to the chronic pain complaint.

**Relaxation.** Most patients with chronic pain have muscle tension which increases the pain. Patients are instructed in proper breathing and progressive muscle relaxation and autogenic relaxation procedures.

**Biofeedback.** Biofeedback is used in instructing patients to decrease muscle tension and increase vasodilation. In this way, patients learn to control and regulate their own body functions.

**Behavior Modification.** Chronic pain patients adopt lifestyles which are counterproductive. They remain inactive, rely on excessive amounts of medication, and fail to assume responsibilities at work or home. This may be improved by patient education, monitoring of behavior, goal setting, family group therapy, praise, and positive reinforcement.

Chronic pain patients may be managed either as outpatients or inpatients. Ninety-five percent of the patients seen at Vanderbilt Pain Center are outpatients. The outpatient approach is preferable, since it is less costly and easier to influence behavioral change. The patient can still remain in his or her environment, deal with it, and not become dependent on the medical system.

Some special studies for chronic pain patients involve heat beam, dolorimetry, measurement of vasoactive principles (e.g., endorphins), thermography, and psychometric testing.

Occasionally, lumbar sympathetic and stellate ganglion blocks are helpful. Trigger point injections are done occasionally as well as facet blocks and ligamental blocks. These should be reserved for the specialists. Chlorzoxazone and acetaminophen and diflunisal are helpful for chronic back pain. Piroxicam and ibuprofen can be used

successfully in treating cervical arthritis, as can propranolol and ersotamine.

Drug management of chronic pain patients requires a higher degree of sophistication than patients with acute pain. Physicians must consider not only the pain mechanisms but also the psychologic factors and coping skills in the patient's problem, since there is a high incidence of iatrogenic complications in such patients, mostly from ill advised drug prescriptions and drug misuse. For this reason, drug management of chronic sufferers should follow a structured pharmacologic plan where drugs may be offered to potentiate the overall goals of long-term pain control programs.

If the pain is of fairly recent origin, try non-narcotic analgesic, antidepressant, and non-steroidal anti-inflammatory agents on a timed schedule. Encourage maintenance of daily activities, prevent onset of learned pain, assess after 3 months.

If the pain is of a long duration, it may require treatment in a pain control center. The illness, behavior, and biomedical findings can be assessed and correlated in clear anatomic and physiologic patterns. Psychosocial and functional assessment, reassurance, counseling, and relaxation training can be provided. To prevent overtreatment, the patient should be informed of the risks of further treatment including drug misuse, unnecessary surgery for pain, unnecessary hospitalizations and diagnostic procedures, and quack procedures.

In a medical atmosphere that relies heavily on biomedical intervention, these patients can be expected to float from one specialist to another with considerable risks of incurring iatrogenic pain. Because every patient has access to drugs and well meaning physicians ready to prescribe them, the responsibility of appropriate medication is ultimately the patients.

Chronic pain patients are not necessarily drug addicts. They misuse drugs out of ignorance and iatrogenic drug prescribing. The goal of any long-term management of chronic pain patients is to lead them

away from the notion that drugs are the ideal treatment. Properly informed, many such patients are willing to discontinue pain medications and ask for alternatives.

The Social Security Commission on Pain and Disability has recognized that the single most useful way to help physicians and patients when confronted with a problem of chronic pain is professional education. It has recommended that regional seminars be organized within the Social Security system to educate medical and legal professionals about problems of chronic pain. In a similar way, regional seminars may be organized throughout the State of Georgia by appropriate agencies for educating physicians on various topics of chronic pain. The American Academy of Pain Medicine is presently working to establish a *National Registry of Pain*. In a similar way, a pain registry for the State of Georgia could be established by an appropriate agency. Such pain registry may include the following: a list of appropriate articles published in the various journals of pain, such as "Pain," "The Practice," "Topics in Pain Management"; a list of physicians who are members of the American Academy of Pain Medicine; a list of CARF-certified pain control facilities in the State of Georgia.

### Summary

There is a mounting national consensus that chronic pain syndrome does exist and is presently unrecognized and undiagnosed by a large majority of physicians. By failing to recognize such a syndrome, physicians may actually foster what is being called an epidemic of chronic pain and disability. There is a resulting high potential for iatrogenic complications, malpractice suits, unnecessary high cost of health care and, most important of all, unnecessary prolonged suffering for the individual chronic pain patient.

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# The New Medical Education in Georgia

J. R. Swartwout, M.D.

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**A major change in the manner of delivery of medical education encompassing these recommendations (of the GPEP report) began in Georgia in August, 1982, when Mercer School of Medicine enrolled its charter class.**

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**A**TEMPTS TO IMPROVE medical education have occurred throughout the course of medical history. Dramatic enhancement of the educational process resulted from the Flexner report of 1910.<sup>1</sup> A recent recommendation for change came from the Association of American Medical Colleges in its report on the general professional education of the physician entitled, "Physicians for the Twenty-First Century" (GPEP report).<sup>2</sup> In this September, 1984, document, several changes are recommended and include the following:

1. "Medical faculties should offer educational experiences that require students to be active, independent learners and problem solvers, rather than passive recipients of information."

2. "Medical faculties should examine critically the number of lecture hours they now schedule and consider major reductions in this passive form of learning."

**A** major change in the manner of delivery of medical education encompassing these recom-

mendations began in Georgia in August, 1982, when Mercer School of Medicine enrolled its charter class. The basic science curriculum of the freshman and sophomore years is composed of three ½-day sessions per week in which small groups of students (with a faculty facilitator) dissect a written medical problem into its basic sci-

ence components. The students, in their free time, acquire information on these components from standard textbooks, from periodicals, from audio-visual sources and from the faculty. After assimilating an appropriate-sized data base of basic science concepts, the students at a scheduled session discuss these concepts, exchange information, and apply the acquired data base to solving the medical problem at a level of sophistication in keeping with the students' progress through the curriculum.

Curricular design includes an organized progression of medical problems that leads the student through the body systems and disciplinary concepts. Lists are provided to the students of items that they should know by the end of each of the 6 week blocks (Study Unit Index). At the completion of each segment, the students are given a written multidisciplinary examination and an oral examination on a medical problem requiring synthesis and analytical application of basic science information.

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Dr. Swartwout is Associate Dean for Academic Affairs, Mercer School of Medicine, 1400 Coleman Ave., Macon, GA 31207

## CURRICULUM OUTLINE

	WEEKS	BIOMEDICAL PROBLEMS PROGRAM	CLINICAL SKILLS	COMMUNITY SCIENCE
FRESHMAN AND SOPHOMORE YEARS	18	INTRODUCTION TO BASIC MEDICAL SCIENCE	BASIC INTERVIEWING AND PHYSICAL EXAMINATION	WEEKLY SEMINARS
	4	SELECTIVES	OR	REMEDIATION
	2	RURAL PRECEPTORSHIP		
	52	SYSTEM SPECIFIC PROBLEMS HEMATOLOGY NEUROLOGY ENDOCRINOLOGY RESPIROLOGY GASTROENTEROLOGY RENAL DISEASE CARDIOLOGY INFECTIOUS DISEASE MUSCULOSKELETAL SYSTEM	ADVANCED INTERVIEWING AND SYSTEM SPECIFIC PHYSICAL EXAMINATION ***** COMMUNITY OFFICE PRACTICE PROGRAM	WEEKLY SEMINARS
	4	COMMUNITY RESEARCH AND PRACTICE PROJECT		
JUNIOR YEAR	48	CLINICAL CLERKSHIPS		
		SEQUENCE I INTERNAL MEDICINE (10 WEEKS) SURGERY (10 WEEKS) PSYCHIATRY (4 WEEKS)	SEQUENCE II OBSTETRICS AND GYNECOLOGY (8 WEEKS) PEDIATRICS (8 WEEKS) AMBULATORY MEDICINE (8 WEEKS)	
SENIOR YEAR	32	ACUTE/CRITICAL CARE (4 WEEKS) PSYCHIATRY (2 WEEKS)		RURAL PRECEPTORSHIP (8 WEEKS, ONE HALF MAY BE IN A COMMUNITY SCIENCE ELECTIVE)
		ELECTIVES (18 WEEKS)		

Figure 1: The 4-year curriculum of Mercer School of Medicine in Macon, in time sequence from top to bottom. Vacations and other unassigned times are not shown.

Throughout the first 2 years, the students participate in three other concomitant programs. In the first, the students are assigned to a practitioner's office to observe and to do appropriate tasks. The second program consists of exposure to the discipline of community health. A project on that subject is required and must be completed prior to graduation. The third is a program on clinical skills that uses trained lay persons as surrogate patients. The clinical years are, of course, also problem oriented, require problem solving and are approached via a small group format. Traditional clinical rotations have always been in that mode, and Mercer's are similar to those of other medical schools. An outline of the entire curriculum is shown in Figure 1.

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**The desired outcome of this educational approach is to produce physicians who are self-learners with a lifetime habit of obtaining and evaluating new information and who work well with other people to solve health problems in Georgia.**

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The desired outcome of this educational approach is to produce physicians who are self-learners with a lifetime habit of obtaining and evaluating new information and who work well with other people to solve health problems in Georgia. It will take several years to determine whether Mercer graduates will have more of these abilities. The only external measure of this educational system presently available is performance on the National Board of Medical Examiners test. On the basic sciences part, the classes of 1987, 1988, and 1989 have had a passing rate of 95% on the first try, with a mean score slightly above the national average. This at least proves that medical students can learn basic sciences without exposure to formal lectures in these disciplines. The classes of 1986,



1987, and 1988 had a passing rate on Part 2 of 100% on the first try, with a mean score slightly below the national average.

**I**t is inappropriate for change to occur just for the sake of change. It is very appropriate for change to occur in response to the criticisms of medical education that have come from many persons and groups. These criticisms have been well delineated in the GPEP report. Mercer, a new school, has been in an excellent position to respond to curricular suggestions, since it has not been burdened with the inertia of tradition. Thus, the trial of new

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**It is very appropriate for change to occur in response to the criticisms of medical education that have come from many persons and groups. These criticisms have been well delineated in the GPEP report.**

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learning approaches has been done in a more complete way than that accomplished by adding a second track to a traditional curriculum. Medical professionals in Georgia have the opportunity to observe this trial of concepts of medical education and can help this faculty judge the outcome and the final product.

#### References

1. Flexner A. Medical Education in the United States and Canada. D. B. Updike, The Merrymount Press, Boston 1910.
2. Physicians for the Twenty First Century. Association of American Medical Colleges, 1984.

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# Telling the Whole Truth — Optimist or Crepe Hanger?

Roland Summers, M.D.

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**A glimmer of hope serves as an incentive to fight for survival, making the final months of illness more bearable. With hope, it's easier to stay alive and it's easier to die, too.**

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**T**O NEW MEMBERS of the Memorial Medical Center House Staff, as Chairman of the Graduate Medical Education Committee, let me welcome you to an exciting and new challenge in your educational career.

As a past-preppie physician approaching middle age, I have arrived at the receiving end of the healthcare system, along with many friends and relatives. It is from this vantage point that it has become painfully evident that a certain calousness has spread among physicians over the past few decades. As a physician who has shared experiences from both sides of the bedrails, let me share a few thoughts with you.

**A** friend of mine who was hospitalized for a myocardial infarction 4 years ago related that 2 days after he was admitted a young resident was examining him, and the older physician commented casually, "You know, I feel remarkably well, considering it's been only 48 hours since my coronary." "Don't let that deceive you," responded the intern, "you're in serious danger." Next, an intern, while shaking his

head knowingly and whipping an EKG strip through his hands, stated, "I don't like your EKG." It was at that point the patient/physician asked his own attending about his chances of recovery. "It's too early to tell," was the doctor's only commitment.

No doubt these doctors were imparting the unvarnished truth, but the physician couldn't help comparing them to himself and other

older, more compassionate members of medicine.

The senior cardiologist stated, "Barring any unforeseen developments, your chances are excellent. Your EKG shows the expected evolution, and you're making progress."

**L**est you think I am overly sensitive or critical only of my younger colleagues, consider the case of Anne, a close friend.

On her first visit to an established surgeon, Anne was told that her breast cancer was inoperable. The surgeon added that he could "hold out no hope whatsoever." "How long do I have to live?" Anne queried. "One or two years" was his pronouncement. Anne was devastated, as you might imagine — and far more so than she might have been had the surgeon offered a dram of hope. What would it have cost him to have added a milder modifier, such as, "Of course, I've seen similar cases in which patients have done remarkably well for many years"?

In fact, thanks to chemotherapy, Anne was able to go skiing in Switzerland 3 years later; but the surgeon

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This article is the introductory talk Dr. Summers made as President of the Georgia Medical Society to incoming residents at Memorial Medical Center in Savannah.

Dr. Summers specializes in internal medicine and pulmonary diseases. Send reprint requests to him at P.O. Box 23677, Savannah, GA 31403.

was not around to share her good fortune . . . he'd died of a heart attack 2 years earlier!

Sometimes I've wondered how he might have reacted if someone had told him just before he saw Anne that he had only a year to live — particularly if his physicians reminded him once a week that although he was feeling fine, early death was unavoidable.

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**Not only does  
negativism sour  
patients on legitimate  
palliative or life-  
extending medicine,  
but it denies them the  
therapeutic effort of  
the visit itself.**

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That's what eventually drove Anne to quit chemotherapy. Yes, it was helping her to survive, but she could not endure the steady stream of bad news bulletins from the treatment team. Through sophisticated screening, they'd tell her new nodules had been found here and there; and, in essence, the doctors used every visit as an opportunity to give Anne a new death sentence.

In conversations with me, it was obvious that Anne was all but begging for someone to let her see a ray of hope. When she got it, she turned to an expensive "quack" who ridiculed chemotherapy and lifted her spirits with promises of a diet and vitamin cure.

A short time after she abandoned medicine — or, was it the other way around?? — Anne was dead.

What prompts a physician to report each new metastatic lesion to a patient who is already staring death in the face? Could it be professional pride, an urge to show off his cleverness at detecting mag-

nignancies that have not yet produced symptoms? Certainly it's not because he feels it will help that patient in any way.

**I**n the past, most physicians couldn't help realizing that medicine is both an art and a science. And most considered it their duty to comfort when they could not heal.

However, as science has advanced the ability to heal, many of us have neglected to master the art of comforting. Moreover, some openly argue against it now, maintaining that patients must be "told the whole truth, and nothing but the truth" to guard against malpractice litigation.

The sad fact is that — because of the professional vanity, fascination with technology, a consuming fear of attorneys, or whatever — too many doctors have misplaced their compassion. They concentrate blindly — even misanthropically — on the negative.

**T**ake the case of Mildred, a relative of mine. When exploratory surgery revealed her liver cancer, she was referred to an oncologist.

She told me that after the doctor read her pathology report, he reached into his desk drawer and withdrew a slender stick. "This is what you need," he said, waving it in front of Mildred and her husband, Frank. "What is it?" asked Mildred. "It's a magic wand," the oncologist replied. "That's the only thing that will help you now." When she recounted the incident to me, Mildred said, "The man actually grinned when he said this. Did he think I would find it funny?"

Since he kept the wand in his desk, the doctor apparently employed this "technique" quite often. Yet, he never mentioned to Mildred that periods of remission were possible, even predictable, in cases like hers. The encounter had a devastating effect on her, doubling the burden of her disease with iatrogenic depression.

When painted into such a dark corner by a physician, it's not surprising that even the most intelligent and educated patient will quit medicine in favor of quackery. And, a myriad of quacks will happily accept a sick person's fortune in payment for vague claims laced with sympathetic encouragement.

"Six months ago," Mildred told me, "I would have laughed at anyone who went to a psychic or acupuncturist because he claimed to achieve long-term cancer remissions. Now I'm seeing both." Mildred felt she could either do that or succumb to the doctor-induced depression.

Unfortunately, patients are often provoked to turn their backs on medicine at a stage when it can still offer them a great deal of temporary of palliative help — and, once in a while, even a cure.

**S**uch a tragedy was narrowly averted in a friend of mine named Bill. He'd been on some medication that made his white count drop to ZERO. After a few days' hospitalization, a consulting hematologist explained the gravity of the situation to him in cold detail, ending with the statement: "The outlook is grim, and your chances of recovery are minimal."

In reaction, Bill told his family he wanted to end reverse isolation, along with all other treatment, and go home to die. It took a lot of persuading by his wife and sons to counteract the doctor's hopeless prognosis, but Bill decided to stay in the hospital, and on the 5th day his white count was 300; but on the 8th day it was back to normal. Today, Bill is fine. What he remembers most about his illness is the hematologist's lecture.

I don't question the need to fully inform the patient and family, but I do wonder what harm would have been done if the doctor had tempered his gloomy opinion with such words as "So far your lab tests don't show the improvement I've been hoping for; but, on the other hand,



the tests only give part of the picture. Your positive attitude and strong constitution are factors in your favor."

**T**here are any number of ways to cushion the blow when it looks as if nothing short of a miracle will help a patient. A doctor might say, "Every day the survival statistics improve for people with this type of illness. Long range, your life expectancy may be less than we would both like it to be, but certainly there is no reason to give up hope. We can remain cautiously optimistic."

Even the AIDS patient can be honestly told, "People differ in their ability to resist the progress of this disease. You could well have long periods in which your life will be quite normal. Also, advances in treatment are being achieved all over the world. Some exciting new drugs are being developed right now, and no one knows how quickly they could become available. It's hard to do, but bear in mind that help is on the way."

What happened to this part of truth in medicine? I suspect that the physicians who have the crepe-hanging tendency are oblivious to it, because most patients are too polite, intimidated, or preoccupied by illness to speak up.

**O**f all the friends who have complained to me about the "Prophet of Doom" physicians, only Zack had the wherewithal to do something about one. As he recalled the confrontation

which occurred in the hospital, he said, "Doctor, I am not quite sure how to put this, but after each of your visits I feel worse than before. Already I know I'm real sick, so don't bother telling me that over and over again. In fact, unless you can bring me some good news, why don't you just stay away?"

Taken aback, the physician sat down at Zack's bedside and said, "Tell me more. If I'm doing this to you, I must be doing it to other patients, too."

They worked out a more cheerful relationship for the duration of the illness and have been freinds ever since. Clearly, it would have been better had the doctor behaved like a friend from the outset, recognizing the damage the discouraging words can cause.

Not only does negativism sour patients on legitimate palliative or life extending medicine, but it denies them the therapeutic effect of the visit itself.

Norman Cousins and others have repeatedly demonstrated that what a physician says to his patient can be physiologically beneficial in no small degree. It can motivate, reassure, and sometimes represent the best treatment that's available. A glimmer of hope serves as an incentive to fight for survival, making the final months of illness more bearable. With hope, it's easier to stay alive and it's easier to die, too.

I am not suggesting that our profession is devoid of doctors who do understand the positive impact

of comfort and reassurance, even when given cautiously mindful of legal constraints.

And, there are patients who don't seem to care much either way. But, as one such woman reported to me after seeing her oncologist, "I told him I was ready to meet my Maker, and do you know what he said?" He said, "I am not sure your Maker is ready to meet you. Certainly your children aren't ready to turn you over to Him just yet!" Said the woman, "That made me think he doesn't expect me to die so soon." Needless to say, she was buoyed by the statement.

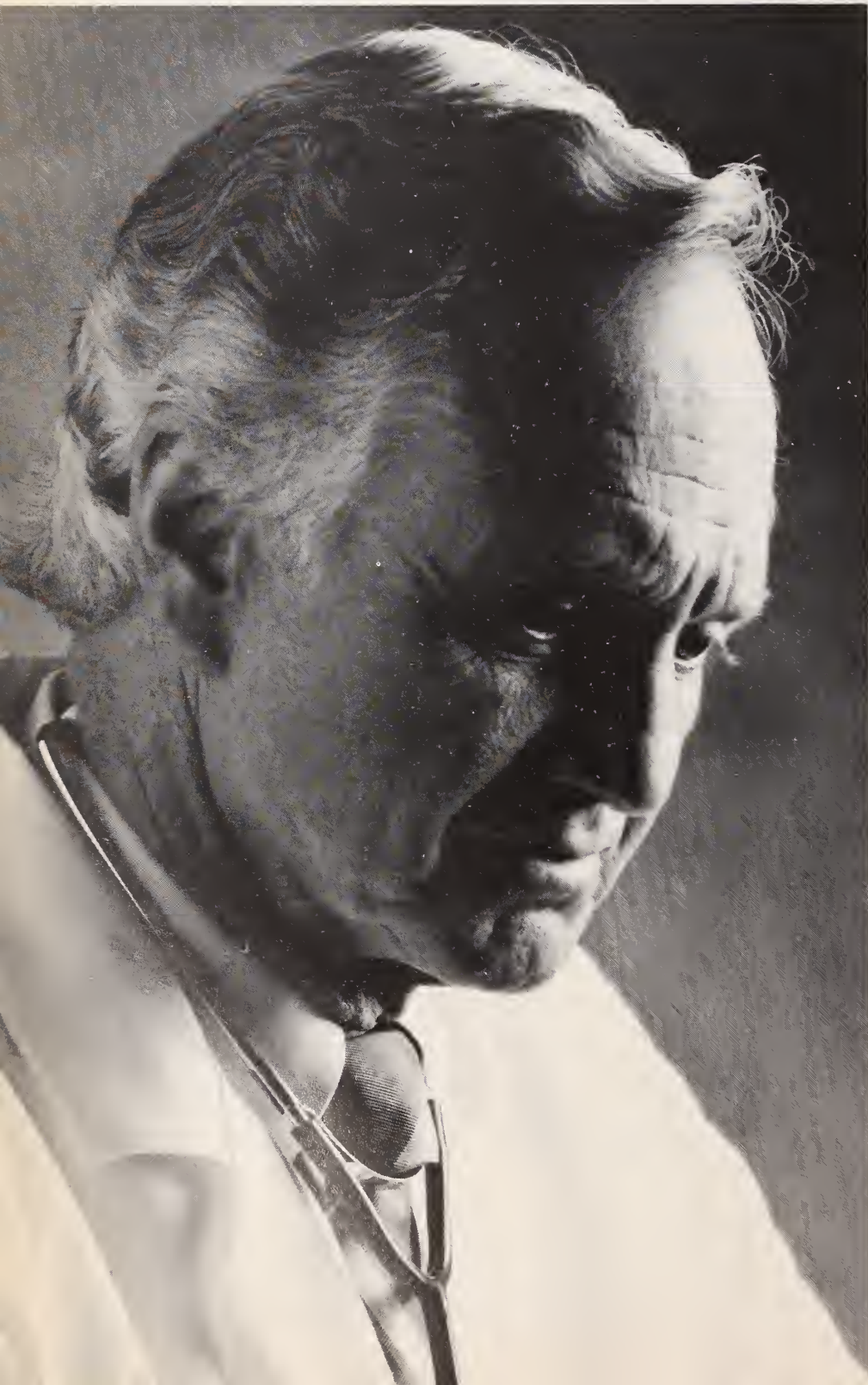
Physicians who possess the mysterious ability to make patients feel better merely by talking with them have mastered the art of comforting. In large part, it's a matter of conveying optimism. That's what patients need most when their health is declining.

Of course, the prognosis, however bleak, must be truthful. But, a doctor who provides the patient only with textbook translations of laboratory reports is, at best, merely a competent scientist. The sick person rightfully expects his physician to help him through any illness, especially the final one; and a real medical professional does just that.

Once it was common to hear patients say, "The doctor was here; I feel better." This can be so again if we remember:

"TO CURE — SOMETIMES . . .  
TO COMFORT — ALWAYS."

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surgeons in the operating room, the primary care physician, the anesthesiologist and the hospital.

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# Report of the Georgia State Cancer Registry, 1975-1985

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## Introduction

**T**HE GEORGIA State Cancer Registry (GSCR) was established in 1974 as a voluntary, statewide system for collecting information on cancer patients in Georgia. For 12 years the Registry was operated by the Medical Association of Georgia under contract from the Georgia Department of Human Resources. Since July, 1986, the GSCR has been maintained by the Georgia Center for Cancer Statistics at Emory University.

The purpose of this report is to summarize the data collected on patients throughout Georgia diagnosed with cancer between 1975 and 1985. The emphasis of these analyses is on racial differences in the distributions of anatomic site, stage, and survival for cancer patients in Georgia.

## Abstract

**A** TOTAL OF 80,188 PATIENTS with newly diagnosed cancer between 1975 and 1985 were reported to the Georgia State Cancer Registry through July, 1986. Of these patients, 75.5% were white and 24.5% were black. Overall, cancer of the respiratory system was the most common form of neoplasia, accounting for 18.3% of all cases. Blacks had elevated relative frequencies of malignancies of the uterine cervix, prostate and digestive organs other than the large intestine. The percentage of localized disease was greater among whites (40.5%) than among blacks (30.2%). The racial disparity in stage was greatest for cancers of the oropharynx. The overall 5-year survival rate was 43% for whites and 31% for blacks. Within each race, the most favorable prognoses were found for neoplasms of the female breast and uterus. For each primary anatomic site of occurrence, stage was found to be a strong prognostic factor.

## Materials and Methods

Information on cancer patients was collected by personnel at participating hospitals throughout Georgia. A total of 33 hospitals (see Appendix) submitted data for at least part of the present study period. The staff of the GSCR provided training for hospital personnel in the methods of case-finding and abstracting. In addition, a procedure manual was developed and used to promote consistency in the methods of data acquisition.

Patients with any malignant neoplasm, except for squamous or basal cell carcinomas of the skin, were eligible for registration. Information on demographics, diagnosis, topography, stage, morphology, stage, and initial treatment was transcribed onto standard

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TABLE 1 — Frequency of cancer registrations by primary anatomic site, race and sex, 1975-1985

Anatomic site	White				Black			
	Male		Female		Male		Female	
	n	%	n	%	n	%	n	%
Oropharynx	1,687	( 5.6)	994	( 3.3)	486	( 4.8)	260	( 2.7)
Colon	1,908	( 6.3)	2,448	( 8.0)	499	( 5.0)	837	( 8.8)
Rectum	950	( 3.2)	941	( 3.1)	254	( 2.5)	312	( 3.3)
Other digestive organs	1,848	( 6.1)	1,376	( 4.5)	1,203	(12.0)	803	( 8.4)
Respiratory system	8,435	(28.0)	3,006	( 9.9)	2,581	(25.7)	650	( 6.8)
Breast (female)	—	—	8,137	(26.7)	—	—	2,275	(23.8)
Uterine corpus	—	—	2,204	( 7.2)	—	—	578	( 6.1)
Uterine cervix	—	—	1,622	( 5.3)	—	—	1,346	(14.1)
Ovary	—	—	1,356	( 4.5)	—	—	337	( 3.5)
Prostate	4,727	(15.7)	—	—	2,564	(25.5)	—	—
Urinary tract	2,567	( 8.5)	1,081	( 3.6)	491	( 4.9)	305	( 3.2)
Hematopoietic system	1,434	( 4.8)	1,263	( 4.2)	495	( 4.9)	468	( 4.9)
Lymph nodes	1,113	( 3.7)	1,081	( 3.6)	218	( 2.2)	172	( 1.8)
Other	3,100	(10.3)	3,065	(10.1)	469	( 4.7)	541	( 5.7)
Unknown	2,365	( 7.8)	1,868	( 6.1)	799	( 7.9)	669	( 7.0)
All sites	30,134	( 100)	30,442	( 100)	10,059	( 100)	9,553	( 100)

data collection forms and forwarded to the GSCR. The abstract form included all core data items required by the Commission on Cancer of the American College of Surgeons. A duplicate copy of each abstract was retained by the hospital for its own registration activities. The transmitted forms were manually edited for completeness and consistency at the GSCR and then entered into a computer database. Abstracts that required correction or further clarification were returned to the reporting hospital for subsequent resubmission.

Follow-up data on disease progression and vital status were collected by hospital personnel on standard forms and then forwarded to the GSCR for entry into the computer database. Typical sources of follow-up information included hospital records, reports from the offices of physicians, and annual lists of deceased persons from vital registrations. Participating hospitals were encouraged to follow the guidelines of the American College of Surgeons for the collection of follow-up information.

The present study population was limited to white and black patients

with dates of diagnosis between 1975 and 1985. Subjects were classified according to race, sex, primary anatomic site (14 groupings of specific topographic codes), and stage (localized to site of origin, extension to regional sites and/or lymph nodes, or metastatic spread). Distributions of attributes were analyzed with standard methods for categorical data.<sup>1</sup> Survival analysis was performed using the Kaplan-Meier product limit estimation procedure,<sup>2</sup> with death from cancer as the outcome.

### Results

As shown in Table 1, 80,188 patients were eligible for inclusion in this report. Within this sample, 60,576 patients (75.5%) were white and 19,612 patients (24.5%) were black. Among whites, females accounted for slightly more than half of all registrants. Among blacks, however, there was a slight excess of cases among males. The primary anatomic site of involvement was known for 92.9% of all reported cancers. The percentage of cases with unknown site of origin did not differ greatly by either race or sex. Overall, the most common form of

cancer was neoplasia of the respiratory system (including lung and bronchus), which accounted for 14,672 cases (18.3% of all registrations). Cancer of the female breast was the next most frequent neoplasm, with a total of 10,412 cases (13%). The third most common cancer was prostatic neoplasia (n = 7,291, 9.1%).

Cancer of the respiratory system accounted for substantially higher percentages of cases among males (whites, 28.0%; blacks, 25.7%) than females (whites, 9.9%; blacks, 6.8%). Similar relative excesses for males were noted at other smoking-related cancer sites (e.g., oropharynx and urinary tract).

Cancers of digestive organs other than the large intestine (e.g., esophagus and pancreas) accounted for larger percentages of malignancies among blacks than whites. The relative frequency of prostatic neoplasia also was higher among blacks (25.5%) than whites (15.7%). Among females, cancer of the uterine cervix accounted for a higher percentage of malignancies for blacks (14.1%) than whites (5.3%). There were only small racial disparities in the relative fre-



TABLE 2A — Percentage distribution<sup>1</sup> of cancers by stage and anatomic site among whites, 1975-1985

Anatomic site	n	Stage			
		Local	Regional	Distant	Unstaged
Oropharynx	2,452	49.4	43.1	4.9	2.6
Colon	3,954	33.8	42.7	21.0	2.4
Rectum	1,752	39.6	40.9	16.3	3.3
Other digestive organs	3,016	24.2	34.3	32.7	8.8
Respiratory system	10,813	28.4	29.0	33.8	8.9
Breast (female)	7,346	51.3	39.7	7.6	1.4
Uterine corpus	2,113	76.2	14.7	6.5	2.6
Uterine cervix	1,501	54.8	37.6	6.0	1.6
Ovary	1,174	27.9	14.0	55.3	2.8
Prostate	4,326	60.2	11.6	16.9	11.3
Urinary tract	3,331	67.1	18.4	9.8	4.7
Hematopoietic system <sup>2</sup>	2,383	—	—	100.0	—
Lymph nodes <sup>2</sup>	1,914	—	—	100.0	—
Other	5,622	73.6	14.6	5.5	6.2
Unknown	3,968	—	7.4	79.1	13.5
All sites	55,665	40.5	24.8	29.0	5.7

1. Percentage of cases within a designated anatomic site.

2. All hematopoietic system malignancies and lymphomas were classified as systemic.

TABLE 2B — Percentage distribution<sup>1</sup> of cancers by stage and anatomic site among blacks, 1975-1985

Anatomic site	n	Stage			
		Local	Regional	Distant	Unstaged
Oropharynx	722	22.4	65.5	9.6	2.5
Colon	1,260	25.7	43.6	26.2	4.4
Rectum	532	28.0	39.1	25.7	7.1
Other digestive organs	1,948	23.8	31.9	34.6	9.7
Respiratory system	3,152	24.3	30.0	34.9	10.8
Breast (female)	2,117	36.8	47.2	14.3	1.7
Uterine corpus	555	54.4	25.2	16.9	3.4
Uterine cervix	1,274	44.6	44.9	8.6	2.0
Ovary	315	21.0	18.4	55.2	5.4
Prostate	2,435	46.7	7.4	30.8	15.1
Urinary tract	760	49.1	28.0	15.7	7.2
Hematopoietic system <sup>2</sup>	884	—	—	100.0	—
Lymph nodes <sup>2</sup>	362	—	—	100.0	—
Other	952	58.5	19.6	10.0	11.9
Unknown	1,438	—	4.7	80.7	14.6
All sites	18,706	30.2	27.9	34.0	7.9

1. Percentage of cases within a designated anatomic site.

2. All hematopoietic system malignancies and lymphomas were classified as systemic.

frequencies of cancers of the large intestine, respiratory system, female breast, uterine corpus, ovary or hematopoietic system.

The stage distributions of malignancies by primary anatomic site are presented in Tables 2A and 2B for whites and blacks, respectively.

Overall, the stage at diagnosis was known for 93.8% of cases. The percentage of unstaged cases was slightly higher for blacks (7.9%) than whites (5.7%). Within each racial group, the relative frequency of unstaged disease was elevated for cancers of the prostate and for those

with unknown primary anatomic sites.

For all sites combined, 40.5% of white patients had localized disease, compared with only 30.2% of blacks. At virtually every anatomic site of cancer, whites were more likely to have localized lesions than

TABLE 3A — Five-year survival rates by anatomic site and stage for whites, 1975-1985

Anatomic site	Stage				
	All	Local	Regional	Distant	Unstaged
Oropharynx	54	72	40	9	26
Colon	49	78	49	7	12
Rectum	47	72	42	4	21
Other digestive organs	12	24	14	4	4
Respiratory system	17	39	16	3	5
Breast (female)	70	84	63	16	40
Uterine corpus	78	87	58	15	59
Uterine cervix	67	83	52	10	16
Ovary	40	81	49	18	22
Prostate	56	68	57	23	48
Urinary tract	56	70	32	12	35
Hematopoietic system <sup>1</sup>	23	—	—	23	—
Lymph nodes <sup>1</sup>	50	—	—	50	—
Other	61	68	55	20	32
Unknown	7	—	13	5	17
All sites	43	69	40	14	21

1. All hematopoietic system malignancies and lymphomas were classified as systemic.

TABLE 3B — Five-year survival rates by anatomic site and stage for blacks, 1975-1985

Anatomic site	Stage				
	All	Local	Regional	Distant	Unstaged
Oropharynx	28	51	24	9	16
Colon	40	66	47	5	14
Rectum	29	60	26	4	18
Other digestive organs	7	13	7	3	4
Respiratory system	12	30	13	2	6
Breast (female)	54	78	51	12	30
Uterine corpus	46	64	36	4	33
Uterine cervix	54	77	42	2	51
Ovary	34	72	37	18	— <sup>2</sup>
Prostate	42	59	38	18	42
Urinary tract	36	52	27	10	19
Hematopoietic system <sup>1</sup>	20	—	—	20	—
Lymph nodes <sup>1</sup>	44	—	—	44	—
Other	46	56	42	21	20
Unknown	5	—	13	3	13
All sites	31	56	31	11	20

1. All hematopoietic system malignancies and lymphomas were classified as systemic.

2. Too few cases available to allow estimation of five-year survival.

blacks. The racial disparity in stage was particularly prominent for cancers of the oropharynx, where the proportion of localized tumors was more than twice as great among whites. Other anatomic sites with excesses of nonlocalized disease among blacks included the large intestine, female breast, uterine corpus and cervix, prostate and urinary tract. Comparatively little racial differential in stage was observed for

cancers of the respiratory system or digestive organs other than the large intestine.

Within each racial group the greatest proportions of localized lesions were observed for uterine corpus cancers (whites, 76.2%; blacks, 54.4%) and those of "other" sites, which included thyroid and nervous system tumors and melanomas (whites, 73.6%; blacks, 58.5%). The anatomic sites of can-

cer with the smallest percentages of localized disease were digestive organs other than the large intestine (whites, 24.2%; blacks, 23.8%) and respiratory system (whites, 28.4%; blacks, 21.0%).

The observed 5-year survival rates by anatomic site and stage are shown in Tables 3A and 3B for whites and blacks, respectively. Overall, 43% of whites and 31% of blacks who did not die of noncan-



cer causes survived at least 5 years from the time of diagnosis. Patients with unstaged cancers tended to have survival rates that were similar to those for patients with nonlocalized disease. Within each racial group, the probability of survival was strongly related to the stage of disease at diagnosis. Patients with localized malignancies were about five times more likely to survive than were patients with metastatic disease.

Overall, the highest survival rates were observed for cancers of the female breast, uterine corpus and cervix, as well as those involving "other" sites. When detected in an early stage, ovarian and colonic cancers also exhibited relatively favorable outcomes. At the other extreme, malignancies of digestive organs other than the large intestine, and those of the respiratory and hematopoietic systems, and unknown anatomic sites had especially poor prognoses.

For each anatomic site, the overall survival experience of white patients was more favorable than that of blacks. The greatest racial differentials in survival were found for cancers of the oropharynx, uterine corpus, and urinary tract. As previously noted, blacks tended to have more advanced disease for cancers at these anatomic sites. Even within the local and regional stage categories, however, racial disparities in survival were observed for each of these malignancies. There were minimal racial differences in survival for cancers with especially poor prognoses, such as those involving the respiratory or hematopoietic systems, or digestive organs other than the large intestine. The racial differences in survival for metastatic cancers of most anatomic sites also were quite small.

**Discussion**

The GSCR does not include information on all cancer patients in Georgia; however, it does represent a sizable proportion of the statewide experience. According to estimates prepared by the American Cancer Society,<sup>3</sup> the total annual

number of newly diagnosed cancer patients in Georgia during 1980 was 15,000. If that midpoint estimate is extrapolated to the present study period (assuming a linear increase in annual caseload), the total number of Georgians with cancer newly diagnosed between 1975 and 1985 was 165,000. In other words, the GSCR had information on approximately 50% of all new cancer occurrences during this period.

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**It has been estimated that 85% of lung cancer deaths are related to cigarette smoking . . . a comprehensive statewide program in smoking cessation could dramatically decrease the cancer burden in Georgia.**

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**A**ny system of cancer registration based upon voluntary reporting from hospitals may not include a representative sample of patients. In the present context, the participating hospitals tended to be large institutions with established and accredited cancer programs. It is conceivable that these facilities attract patients with cancers that are difficult to diagnose and/or manage. This process has been referred to as "referral-filter bias," in which "the selection that occurs at each stage in the referral process can generate patient samples that are much different from those found in the general population."<sup>4</sup> Indeed, national patient care evaluation studies conducted by the American College of Surgeons have demonstrated marked interhospital differences in the survival experiences of patients with cancers of the breast, prostate, or Hodgkin's disease.<sup>5</sup> These prognostic disparities largely were attributable to interhospital

differences in the distributions of patient age, stage and histology.

With that caveat in mind, the data from the GSCR still can serve several useful purposes. First, this information might help to identify needed cancer prevention activities. For example, malignancies of the respiratory system accounted for over one-fourth of the cancers among men in this population. It has been estimated elsewhere<sup>6</sup> that 85% of lung cancer deaths are related to cigarette smoking. Since smoking cessation can reduce the risk of respiratory malignancies,<sup>7</sup> a comprehensive statewide program in smoking cessation could dramatically decrease the cancer burden in Georgia.

Second, the data from the GSCR provide evidence that patterns of cancer occurrence differ within demographic subgroups. For instance, black persons in this sample had relative excesses of neoplasia of the prostate and uterine cervix. Such information may be particularly useful in targeting demographic groups for preventive services and screening initiatives.

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**The purpose of this report is to summarize the data collected on patients throughout Georgia diagnosed with cancer between 1975 and 1985.**

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Third, the information on stage at diagnosis demonstrated the predominance of nonlocalized disease among both whites and blacks in this population. As an illustration, only half of breast cancers among whites in this study were localized at diagnosis. Among black women, an even smaller percentage (36.8%) of breast cancers were confined to the site of origin. Similar results were found for malignancies of the uterine cervix. Although trends over time were not presented in this pa-



per, separate analyses did not reveal substantial temporal changes in the stage distributions of these cancers. Since stage was an important determinant of survival in this study and elsewhere,<sup>8</sup> and because breast and cervical cancers are amenable to earlier detection, every effort must be made to increase the use of screening methods.

Fourth, the GSCR can provide insights into survival patterns for cancer patients. In the present analyses, survival results were stratified by race, anatomic site and stage. Each of these factors was found to be an independent determinant of prognosis. That is to say, race was related to survival, even after adjustment for the effects of cancer type and stage. Similar racial differentials in survival have been reported in national statistics<sup>9</sup> and, therefore, the present results probably are not entirely attributable to biases from incomplete reporting. Since more than one-fourth of the population of Georgia is black,<sup>10</sup> the racial gap in cancer patient survival represents an important public health concern for this state.

Over the past decade, the GSCR has made strides toward improving the quality and quantity of collected information. The Registry continues to seek new approaches for data gathering. Recently, the GSCR has established a mechanism for hospitals to submit case registrations in computerized format. In addition, the GSCR is collecting follow-up information by computer linkage to other databases, such as the annual file of death certificates for the State of Georgia. It is anticipated that these innovations and others will allow the GSCR to enhance the existing database at a nominal cost.

### Conclusion

Ultimately, the success of a voluntary cancer reporting system de-

pends upon the support and cooperation of hospitals and physicians. The Medical Association of Georgia and the Georgia Department of Human Resources have played key roles in maintaining the GSCR. This effort has resulted in the development of a database that can serve the medical community and health agencies in meeting the cancer control needs of this state.

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### Appendix

The following hospitals have contributed data used in this report:

Phoebe-Putney Memorial Hospital, Albany  
 Sumter Regional Hospital, Americus  
 Athens General Hospital, Athens  
 Grady Memorial Hospital, Atlanta  
 St. Joseph's Hospital, Atlanta  
 Northside Hospital, Atlanta  
 University Hospital, Augusta  
 Glyn-Brunswick Memorial Hospital, Brunswick  
 The Medical Center, Columbus  
 West Georgia Medical Center, LaGrange  
 Medical College of Central Georgia, Macon  
 Memorial Medical Center, Savannah  
 Medical College of Georgia, Augusta  
 South Georgia Medical Center, Valdosta  
 Northeast Georgia Medical Center, Gainesville

Houston County Hospital, Warner Robins  
 Tift General Hospital, Tifton  
 Stephens County Hospital, Toccoa  
 South Fulton Hospital, East Point  
 DeKalb General Hospital, Decatur  
 Emory University Hospital, Atlanta  
 Bulloch Memorial Hospital, Statesboro  
 Cobb General, Austell  
 Coliseum Park Hospital, Macon  
 Henry General Hospital, Stockbridge  
 Humana Hospital Gwinnett, Snellville  
 Wayne Memorial Hospital, Jesup  
 Hart County Hospital, Hartwell  
 John D. Archbold Memorial Hospital, Thomasville  
 Gwinnett Hospital System, Lawrenceville  
 Meadows Memorial Hospital, Vidalia  
 Union General Hospital, Blairsville  
 Joan Glancy Memorial Hospital, Lawrenceville

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# Hemobilia

## A Complication of Hepatic Abscess Secondary to Staphylococcal Endocarditis

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### Introduction

**H**EMOBILIA is a term first introduced in 1948 by Sandblom to describe the occurrence of hemorrhage into the biliary tract as a result of a direct communication between the arteriovenous circulation and the biliary tract.<sup>1</sup> The purpose of this report is to describe a case resulting from infection and to review the early history of hemobilia.

### Case Report

A 13-year-old-boy was admitted to the hospital on December 9, after a 3-day illness that began with fever, anorexia, cough, and vomiting. Despite the use of antibiotics, signs of meningitis developed within 48 hours. Later, an apical systolic murmur was detected and was associated with pulmonary vascular congestion. Blood cultures were positive for *Staphylococcus aureus*. Intravenous methi-

### Abstract

A patient was encountered who had jaundice, colicky abdominal pain, and severe gastrointestinal bleeding due to hemobilia. These findings followed an episode of bacterial endocarditis due to staphylococcus. Liver scan provided a clue to the diagnosis, and celiac arteriography offered definitive information. Once the diagnosis is made, surgery can be life-saving by eliminating the arteriovenous communication. Hepatic artery ligation also is sometimes needed if the sites are small and multiple. This particular patient had a large arteriovenous communication ligated and later, residual small areas required hepatic artery ligation for ultimate success.

cillin and gentamicin were started and continued until discharge approximately 9 weeks later, when he was afebrile and much improved.

During the next several weeks, the patient experienced progressive congestive heart failure associated with a grade III/IV holosystolic murmur at the apex which radiated to

the axilla. Cardiac catheterization led to mitral valve replacement with a Bjork-Shiley valve; coumadin was prescribed for anticoagulation.

On March 24, he developed periodic severe, colicky, peri-umbilical pain followed by massive hematemesis. His bilirubin rose to 7.6 mg % (normal

< 1 mg %) and alkaline phosphatase rose to 340 mμ per ml (normal, 30-85). Upper GI series was normal and gastroscopy unremarkable. On another occasion, during a recurrent bleeding episode, gastroscopy revealed blood in the first part of the duodenum.

Spiking fever and leukocytosis occurred in association with a rising alkaline phosphatase. Multiple filling defects were present on a liver scan (Figure 1). On May 11, suspicion of pyogenic abscesses led to an abdominal exploration and drainage of several hepatic abscesses. Bright red blood was as-

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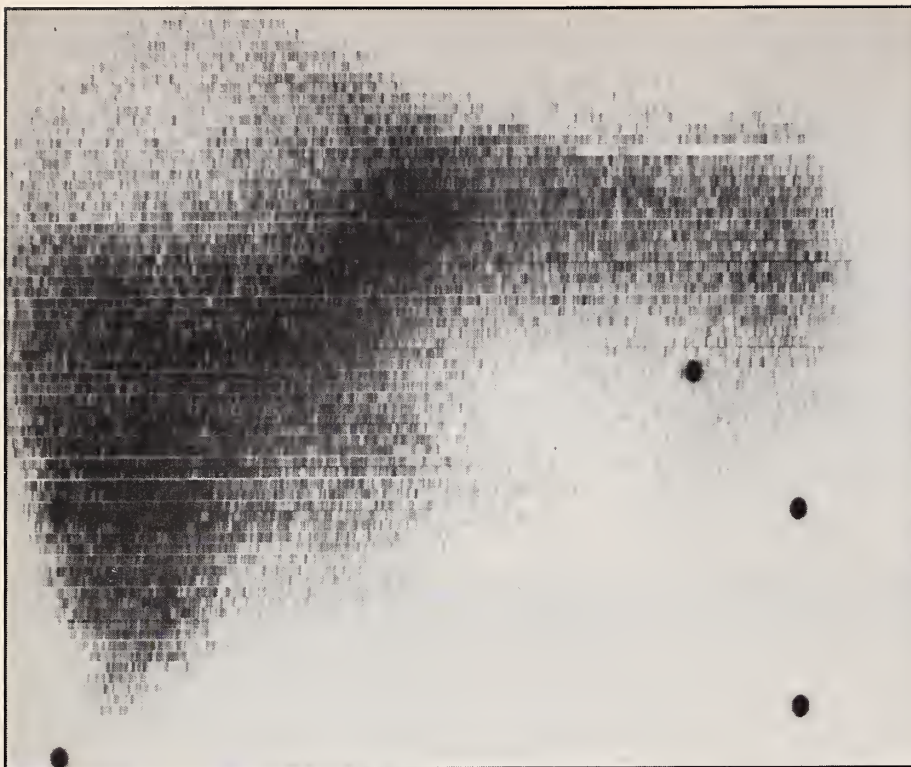


Figure 1. Liver scan showing a large filling defect in the dome of the liver on the right and other, not so well defined, defects in the midline area.

pirated from a large soft pulsatile area in the dome of the right lobe of the liver, and purulent material was aspirated from other areas. Bacterial culture grew *S. aureus*.

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**This case illustrates the classic features of hemobilia, as well as the difficulties encountered in managing a patient with hepatic abscesses eroding into the hepatic circulation and biliary tract.**

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On May 27, mild jaundice was again present (4.5 mg % bilirubin), and a sudden episode of abdominal pain and hematemesis occurred followed by circulatory shock. After stabilization, celiac arteriogram revealed a large arteriovenous communication (Figure 2).

Hemobilia had occurred as a result of the arteriovenous communication emptying directly into the biliary tract.

On May 27, surgery was again performed with elimination of the arteriovenous communication and ligation of all communicating vessels and ducts. One week later, massive bleeding again occurred, and repeat celiac arteriography demonstrated two small arteriovenous communications. Exploration was performed with ligation of the hepatic artery at the celiac axis. Following surgery, hemobilia occurred once more. Transfusions were given, and no additional bleeding occurred. The patient recovered and was discharged after receiving a cumulative total of 57 units of blood.

In January of the following year, he developed acute rheumatic fever, an illness which may explain the predisposition to endocarditis that occurred the year before.

#### Discussion

The occurrence of hemobilia is rare. Although currently the most common cause is trauma, original descriptions of hemobilia date back to the seventeenth and eighteenth

centuries when inflammatory causes were more common. Other mechanisms found responsible are hepatic aneurysm rupture (mycotic and atherosclerotic), hepatic tumors, gallbladder disease, and pancreatic disease.

The first published description of hemobilia was by Glisson in 1654.<sup>2</sup> The source of hemorrhage into the biliary tract was thought to be contusion or penetrating injury. In 1765, Morgagni wrote of the cause of dilation of the bile ducts and attributed to his teacher, Valsalva, an observation that angular gallstones and liver abscesses could cause secondary bleeding into the biliary tract.<sup>3</sup> A pertinent case was mentioned with autopsy findings of an hepatic abscess with clinical symptoms of biliary colic, jaundice, and vomiting, presumed to be secondary to clots obstructing the ductal system.

A case of multiple abscesses resulting in hemobilia was described by Portal in 1777. Portal noted that liver size and colicky pain were diminished after each episode of hemobilia.<sup>4</sup> The vomited blood was noted to be purulent. Autopsy findings confirmed Portal's clinical suspicions. Quinke, in 1871, first noted the triad of biliary colic, jaundice, and gastrointestinal bleeding in a patient with hemobilia.<sup>5</sup>

This case demonstrates an unusual cause of gastrointestinal bleeding: i.e., hemobilia as a result of hepatic abscess secondary to bacterial endocarditis. This case also features the classic presentation of hemobilia with biliary colic, jaundice, and gastrointestinal bleeding. Gastrointestinal bleeding is seen in 90% of cases, while jaundice is evident in 60%, and biliary colic in approximately 70%.<sup>6</sup> The pain is due to bile duct distention from rapid hemorrhage or obstructing thrombus. Inflammatory causes account for 13% of the total cases reviewed by Sandblom in 1972.<sup>7</sup> The great majority of these cases were helminth infections (106 cases). Purulent hepatic abscess was a more common cause of hemobilia in the pre-antibiotic era. Sandblom noted that hemobilia due to infectious causes was often preceded by systemic infection.



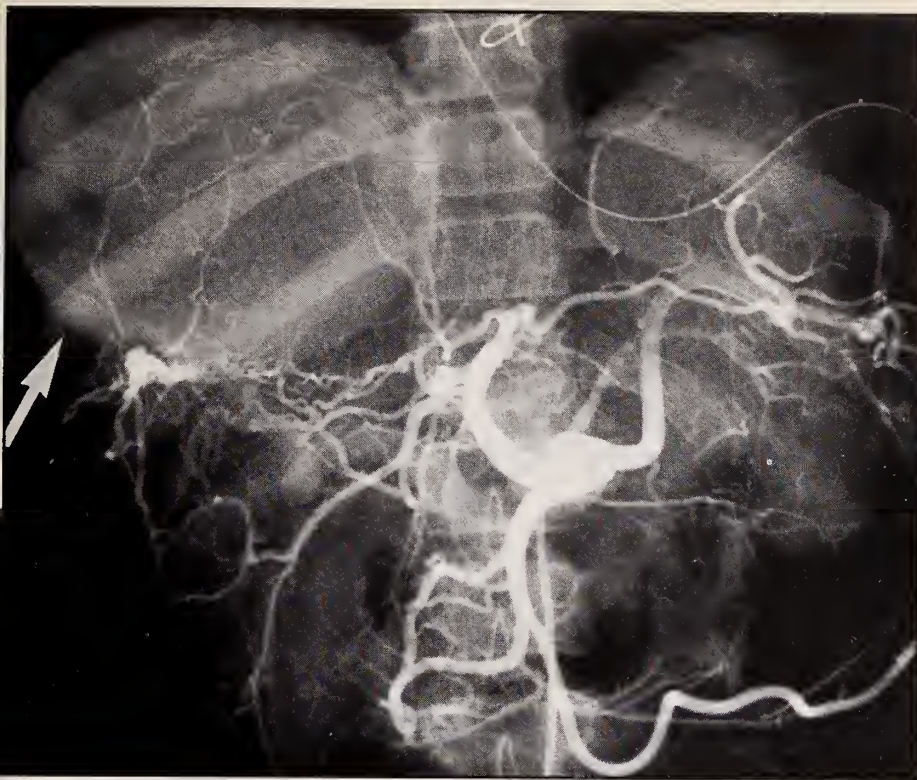


Figure 2a. Celiac arteriogram showing a large grapefruit-sized cavity that is arterialized and drains in part into the portal system. The portal vein is visualized as a venous phase of the arteriogram. Subsequent films a few seconds later showed complete clearing of the contrast material from the liver area. The Bjork-Shiley mitral valve is seen above the diaphragm.

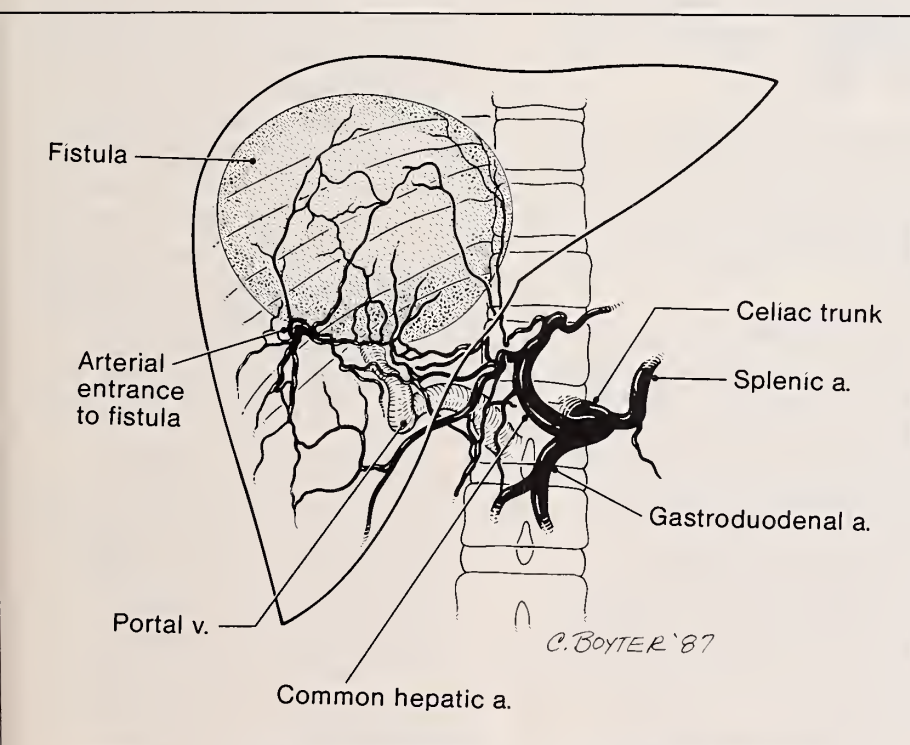


Figure 2b. Line diagram of arteriogram.

## Summary

This case illustrates the classic features of hemobilia, as well as the difficulties encountered in managing a patient with hepatic abscesses eroding into the hepatic circulation and biliary tract. The underlying illness was bacterial endocarditis, an unusual, but not unrecognized, cause of hemobilia. The resemblance of this case to earlier cases in the literature has been noted. The unusual complication of large arteriovenous fistula as a consequence of hepatic abscess is rarely encountered in the current antibiotic era. The clinical presentation of biliary colic, jaundice, and gastrointestinal bleeding is characteristic of hemobilia and when encountered should be approached aggressively since a favorable outcome can occur with medical and surgical treatment.

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## Hepatic Resection for Metastatic Colorectal Cancer

Michael J. Koretz, M.D.

**C**OLORECTAL CANCER remains the most common cancer in the United States not related to tobacco abuse and was responsible for approximately 60,000 deaths in 1987. Metastasis to the liver occur in two-thirds of patients and is commonly the cause of death. Unfortunately, there is no proven effective systemic therapy for metastatic colorectal cancer.

Stimulated by advances in surgical technique and ancillary support, surgeons in the 1960s began resecting liver metastases in highly selected patients. The publication in 1972 of Dr. James Foster's Liver Tumor Survey served as a milestone in the field of hepatic surgery and offered convincing retrospective evidence as to the success obtained.<sup>1</sup> During the past 15 years, numerous institutions have published series with large numbers of patients on the results of hepatic surgery for metastatic colorectal cancer with remarkably similar 5-year disease-free survival rates of approximately 25 percent.<sup>2-4</sup> It is extremely rare to document a 5-year survivor of documented untreated liver metastasis.<sup>5</sup>

There is no doubt that new diagnostic modalities such as CEA tests and the CAT scan have permitted the diagnosis of hepatic metastases at an early stage when surgical extirpation might offer hope for cure. The argument that

***Patients with resectable colorectal liver metastases should be offered the option of curative resection with the expectation of a reasonable chance of long-term survival.***

such results represent only lead-time bias is still raised in some quarters but may be difficult to definitely disprove outside of a questionably ethical randomized trial.

The technique for the actual resection of the liver has been a focus of lively debate among surgeons. As we have gained experience with the ultrasonic dissector, we have come to recommend it as the technique of choice for its controlled dissection of vessels and bile ducts allowing safe and fairly bloodless dissection. A thorough knowledge of liver vascular and

ductal anatomy is necessary for safe hepatic surgery. In the 1980s, many institutions report a mortality rate of less than 5 percent in patients undergoing major resections. Although there is no question that major hepatic surgery can be performed safely with the expectation of cure in 25 percent of the patients, the time has now arrived to study patients prospectively in an effort to determine which should not undergo major hepatic resection. Retrospective evidence offers some insight as to which patients cannot expect to benefit from attempted curative resection.<sup>6</sup> The presence of disease in the portal or celiac lymph nodes appears to be a significant negative determinant of survival as is the presence of more than four metastases. These patients uniformly do quite poorly. However, there does not appear to be any survival differences among patients with one, two, or three metastases. Similarly, survival rates do not appreciably differ between patients with synchronous or metachronous lesions. The presence of a generous tumor-free margin correlates with survival rates as high as 45 percent, indicating the need for surgical expertise.

**U**nfortunately the majority of patients will eventually die of their disease, indicating the need for effective systemic

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therapy. Current trials using biologic response modifiers such as monoclonal antibodies, Interleukin-2, and LAK (Lymphokine Activated Killer) cells may offer promise over the coming decade. Meanwhile, the therapeutic nihilism still espoused by many clinicians is no longer warranted. Patients with resectable colorectal liver metastases should be offered the option of curative resection with the expectation of a reasonable chance of long-term survival.

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## Myths or Facts?

- Even moderate social drinkers may risk liver damage.
- Women are more likely to suffer liver damage from alcohol than men.
- Most victims of liver disease are *not* alcoholics.

All three statements are *true*.

How many did you get right?

Many people are confused about the effects of alcohol on the liver—and *what you don't know can hurt you*.

A pamphlet on *myths* and *facts* tells what you can do to protect yourself and your loved ones. For your free copy, send a stamped self-addressed business envelope to:



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## Understanding Legal Boilerplate

Robert N. Berg

**A**NYONE WHO HAS EVER negotiated a contract is likely to have heard, at some point, a reference to the "boilerplate clauses" in the contract. Generally, these are the provisions which appear at the end of the contract, and which usually are thought by non-lawyers to be understood only by lawyers. Indeed, lawyers oftentimes perpetuate the myth of the "boilerplate clauses" by advising their clients, "Don't worry about those paragraphs; they are only the boilerplate provisions."

While the subjects generally covered in boilerplate provisions are somewhat standard, the specifics of those provisions are not. More importantly, a party's ability to enforce a contract, as well as a court's or jury's interpretation of that contract, may be influenced by or determined solely on the basis of one or more of these boilerplate provisions. Accordingly, it may be a worthwhile effort to understand some of the basics covered in traditional boilerplate clauses. (Examples of these clauses are set out, in parenthesis, following each paragraph heading.)

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**Governing Law.** ("This Agreement is governed by and shall be construed in accordance with the laws of the State of Georgia.") Generally, the parties to a contract are entitled to select the State law which will govern the interpretation and enforcement of the contract. This may be a mere formality in some cases, such as where both of the contracting parties reside in the State of Georgia and the contract will be performed in Georgia. In other cases, however, such as where the parties reside in different States, or where the contract will be performed in various States, the choice of law provision in the contract may be critical in determining the rights of the parties, since the laws of the various States may differ. Moreover, it is important to keep in mind that, in Georgia, a court may ignore the choice of law provision agreed to by the parties, if enforcement of the contract under that State's laws would contravene Georgia policy.<sup>1</sup>

**Entire Agreement.** ("This Agreement constitutes the entire agreement of the parties hereto with respect to the subject matter hereof.") Generally, where the parties to a contract agree that the written contract contains the entire agreement between those parties, any prior oral agreements or understandings with respect to the subject matter of the agreement, not embodied in the

written contract, are unenforceable and of no effect.<sup>2</sup> Thus, if an "entire agreement" provision is included in a contract, it is imperative for each of the contracting parties to ensure that all of the rights, obligations, and duties of the parties, agreed to prior to preparation of the written agreement, are in fact included in the written agreement.

**Waiver.** ("No consent or waiver by either party hereto, to or of any breach or default by the other party hereto, in the performance of such party's obligations under this Agreement, shall be deemed or construed to be a consent to or waiver of any other breach or default in the performance by such other party of the same or any other obligation of such other party under this Agreement.") This very legalistic-looking provision deals with the issue of "mutual departure" — whether the parties to a contract, by their subsequent actions, have mutually agreed to depart from the specific requirements of the contract. If so, a court may find that one party to the contract has waived a breach of that contract by the other party; if not, the court may enforce the contract, against the breaching party.<sup>3</sup> Inclusion of the "waiver" provision is designed to put each party to the contract on notice that, just because one or the other party consents to or does not



enforce his or her contractual rights in one case, that does not mean that party has waived his or her right to enforce that provision of the contract, or another provision of the contract, in case of a similar breach in the future.

**Interpretation.** ("No provision of this Agreement shall be construed against or interpreted to the disadvantage of any party hereto by any court or other governmental or judicial authority, by reason of such party having or being deemed to have drafted, structured, prepared or required such provision.") Inclusion of this boilerplate provision is designed to remove the general presumption, well-settled in Georgia law, that where construction of a contract is ambiguous or in doubt, it will be construed most strongly against the party who prepared it.<sup>4</sup> The above "interpretation" provision attempts to place the parties on an equal footing, such that any ambiguities in the contract should not be construed to the detriment of one party, as opposed to the other party.

**Amendment.** ("Neither this Agreement nor any provision hereof may be changed or amended orally, but only by an instrument in writing signed by all of the parties to this Agreement.") Generally, a written agreement may only be amended by a subsequent written agreement. However, to the extent that the

subsequent acts or statements of the parties may be construed by a court, as described above, as modifying the contractual rights and obligations of the parties, it is important to include an "amendment" provision in order to express the intentions of the parties that such subsequent oral statements *not* be construed as amending the actual written agreement.<sup>5</sup>

**Time is of the Essence.** ("TIME IS OF THE ESSENCE OF THIS AGREEMENT.") In Georgia, time generally is *not* of the essence of a contract. This means that, unless a specific time frame is included in the contract, a party will be given a "reasonable" time to perform his or her obligations. Inclusion of a "time is of the essence" provision is designed to set out the intentions of the parties that, in all cases, the time frames used in the contract are to be strictly construed and enforced (e.g., "prompt" means prompt, not "reasonably prompt").<sup>6</sup>

**I**n conclusion, just as it may be critical to a contracting party to make sure that the correct purchase price or payment terms are included in the contract, it may also be critical to ensure that the contractual "boilerplate" provisions accurately reflect the intentions of the parties. Otherwise, some outside third party — a court or jury — ultimately may interpret the contract in a manner totally

disparate from the intentions of the contracting parties. This, in turn, may result in one or the other contracting party losing the benefits of his or her bargain.

#### Notes

1. See, e.g., *Dothan Aviation Corp. v. Miller*, 620 F.2d 504 (5th Cir. 1980); *Marketing and Research Counselors, Inc. v. Booth*, 601 F.Supp. 615 (N.D. Ga. 1985).

2. See, e.g., *Kelson Cos. v. Feingold*, 168 Ga.App. 391, 309 S.E.2d 394 (1983); *Adams v. North American Business Brokers, Inc.*, 168 Ga.App. 341, 309 S.E.2d 164 (1983); *West View Corp. v. Alston*, 208 Ga. 122, 65 S.E.2d 406 (1951).

3. See, e.g., *Southwest Plaster & Drywall Co. v. R. S. Armstrong & Bros. Co.*, 166 Ga.App. 373, 304 S.E.2d 500 (1983); *Waldrop v. Bettis*, 223 Ga. 715, 157 S.E.2d 870 (1967).

4. O.C.G.A. §13-2-2(5); see, also, *Anderson v. Southeastern Fidelity Ins. Co.*, 251 Ga. 556, 307 S.E.2d 499 (1983); *Kennedy v. Brand Banking Co.*, 245 Ga. 496, 266 S.E.2d 154 (1980).

5. See, e.g., *Cosby v. A. M. Smyre Mfg. Co.*, 158 Ga.App. 587, 281 S.E.2d 332 (1981).

6. O.C.G.A. §13-2-2(9); see, also, *Sneed v. Wiggins*, 3 Ga. 94 (1847).

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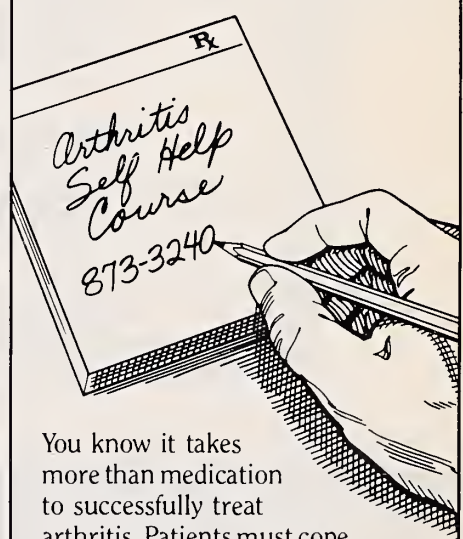


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Sorter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. *N Engl J Med* 1976;294:687-90.

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